HEALTH CARE DELIVERY IN WEST VIRGINIA

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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HEALTH CARE DELIVERY IN WEST VIRGINIA

MONDAY, MARCH 19, 1984

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:30 p.m., in the auditorium, Louis A. Johnson VA Medical Center, Clarksburg, WV, Hon. Bob Edgar (chairman of the subcommittee) presiding.

Present: Representatives Edgar, Mollohan, and Staggers.

OPENING STATEMENT OF CHAIRMAN EDGAR

Mr. EDGAR. The Subcommittee on Hospitals and Health Care will come to order.

I am Congressman Bob Edgar. I am from Delaware County, PA, a little suburb south of Philadelphia. I have been in Congress for the last 10 years and am the chairman of the Hospitals and Health Care Subcommittee of the House Veterans' Affairs Committee. I am here with Congressmen Mollohan and Staggers, who also serve on that committee. We are excited about the opportunity to spend the day in West Virginia and to have a chance to view the Martinsburg and Clarksburg hospitals. We were in Martinsburg this morning.

Our subcommittee has spent the last year trying to figure out what the veterans' health care system is all about. We have been to the six VA medical regions across the country. We spent 2 or 3 days in each of those regions, visiting hospitals and outpatient clinics, and looking at the quality and quantity of veterans' health care across the country. We have seen readjustment counseling centers for Vietnam veterans; we have seen State veterans health care centers where nursing and domiciliary care facilities are shared in a Federal-State relationship; we have seen CAT scanners and dialysis machines and we have seen x ray equipment. We have looked at wards and smaller units. We have looked at old hospitals and new hospitals.

The purpose of these visits was, and is, to assess the value of the veterans' health care system, how it is utilizing its resources, and whether or not we can begin to develop a 5-, 10-, or 15-year plan for the future of veterans health care.

My personal belief is that if the veterans' health care system allows itself to be cannibalized by no additional resources being added to it, or if the aging facilities are allowed to deteriorate, or if the quality of care within the veterans' health care system diminishes, there are a lot of people at the fringes of public policy who

would like to see pieces of the veterans' health care system dissolved or replaced or done away with.

We presently have about $8.5 billion of the Federal budget committed to veterans' health care, out of a total veterans' budget of about $26.2 billion. We have 172 veterans' hospitals across the country, 226 outpatient clinics, and about 135 readjustment counseling centers for Vietnam-era veterans. We have one of the largest health care networks in the world, and one of the best. But it will remain excellent only by continued oversight and planning for the future.

Last week, in order to provide some specific help, given what we learned through our year of study, I was able to convince the subcommittee, including my colleagues Mr. Mollohan and Mr. Staggers, to transfer about $50 million from the VA's construction working reserve fund to the medical care account to provide 1,000 additional staff people for outpatient services. I am pleased that not only did both Congressmen Mollohan and Staggers strongly support my recommendations, but that the full committee also approved it and sent our report on to the House Budget Committee.

In this report we recommended a total of $27.6 billion for veterans' benefits and services, and $9.1 billion of that is for medical care. This is an increase of approximately $600 million for the medical account. My other budget recommendations included an increase in funding of $14.4 million and 190 employees for extended care services; $13.9 million and 21 employees for high-tech equipment, such as CAT scanners and PET scanners; as well as an authorization for 220 additional staff in the Vet Center Program.

One of the important purposes of our field hearings is to learn from the medical center directors how the planning process is going. We are excited today about the fact that we had the opportunity to tour the hospital prior to this hearing so that we have been able to see pieces of the health care system here in Clarksburg.

Mr. EDGAR. I would now like to turn to my colleague, the Honorable Alan Mollohan, for some opening remarks.

Before he begins, I would like to commend him for his leadership on the House Veterans' Affairs Committee. One of the things I said this morning, and repeated to some of the people from the media, is that the House Veterans' Affairs Committee is a relatively small unit. It is 1 of 185 different committees and subcommittees of the House of Representatives. It did not have representation from the State of West Virginia, so it is important that two of the new Members from this State are now members of that committee. Their leadership is important. Sometimes they're nags because they keep pulling on my sleeve and saying "remember our clinical addition in Clarksburg" or "here's a particular problem that we found in a veterans' health care unit here in the State of West Virginia." But that is very important to this State. It is important to have input from the spokesmen who represent this area and I am pleased that this State is well represented on our committee. Not every State gets membership on the House Veterans' Affairs Committee because of the limitation in size, so I think you are well represented now.

I would like to yield now to my colleague, Alan Mollohan.

OPENING STATEMENT OF HON. ALAN B. MOLLOHAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WEST VIRGINIA

Mr. MOLLOHAN. Mr. Chairman, I would first like to thank you very much for holding this hearing and for coming to West Virginia and spending a whole day here. I certainly appreciate the attention you are going to be giving to the Clarksburg hospital and appreciate the opportunity that you gave to the Martinsburg hospital this morning in Congressman Staggers' district. Your leadership and your responsiveness to our nagging is very much appreciated and we are pleased that you take that in the right spirit. We have been nagging a little bit during the last year but we, of course, do want the best for our veterans in this area.

This hospital in my particular area is a very key facility for delivering health care benefits and other services to our veterans.

I would like to thank the hospital staff for the effort that they have put into this hearing. I know they have worked hard in putting together their testimony to tell us about their concerns. As we look to the future, which is what this hearing is really all about, their input will be very important.

I would be remiss, indeed, if I didn't express appreciation for the tremendous crowd that is out here today. This reflects an interest in this hospital and in veterans' programs in the area. I see a lot of friends, and your input, particularly from the service organizations, is very valuable. As I have said on more than one occasion, the Congress listens, as the chairman and Congressman Staggers know, to the veteran service organizations. We value their relationship and it is helpful to us as we try to fashion programs that serve veterans most effectively.

Mr. Chairman, again thank you very much for taking this whole day to be here. I appreciate it personally and I know that the veterans in this area appreciate it very much. Thank you.

Mr. EDGAR. Thank you.

Congressman Staggers.

OPENING STATEMENT OF HON. HARLEY O. STAGGERS, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WEST VIRGINIA

Mr. STAGGERS. Thank you, Mr. Chairman. I, too, want to thank you for being in West Virginia all day. I would like to thank my colleague, Alan Mollohan, also for the hard work and the good job he has been doing on the committee, and cooperating with our office on a lot of the problems and the leadership he has provided for the other colleagues in West Virginia as we address the veterans' issues.

I would also like to commend our chairman for the hard work and leadership he has provided within the committee, being on top of the major issues and being concerned about the veterans. I want to also compliment the people who are here, the veterans' organizations, which we have been able to work with here in West Virginia very closely. I want to also compliment the staff here in Clarksburg.

I am aware of the problems. I am aware of the budgetary problems which we are facing in the Nation. I am aware of the problems that the veterans are facing, especially the aging veterans, the Vietnam veterans, the different service groups which have made these known. I am hopeful, since this facility does serve a large part of my district—and it is a rural district—that we can point out to the committee as this hearing proceeds the problems in rural America and in providing benefits to the veterans in rural America. The counties that are served here by the Clarksburg facility in the Second District do have specific problems, and I am aware of that. Even with the superb staff that you have, we do have problems. I am hopeful that some of these problems can surface as we go through the hearing and we can address those as the committee works its will in the Congress.

I want to thank the chairman again.

Mr. EDGAR. Thank you.

I would just point out to everybody that my district is about as wide as from here to the airport. It is 14 miles across from one end to the other. It is a very urbanized suburb, 520,000 people, well packed into 49 townships and boroughs right outside of Philadelphia. It is really helpful, as Congressman Staggers indicated, for someone like myself, who has a very urban orientation, to come out to the rural parts of our country and find the different kinds of needs here versus those in a really densely populated urban setting. So I am pleased to be here.

Also, I would like to point out the fact that the hospital director has a very serious problem that he is dealing with today. David Kilcoyne's brother tragically had a problem and is undergoing critical surgical procedures, so David could not be with us today. All of our prayers are with him.

Mr. Richard Lawrence, the Associate Director, will lead the panel of people here. We will make all of your printed statements a part of the record and ask that you read or summarize as you see fit.

Richard, it is good to have you here. If you will just have everyone identify themselves for the record before we begin, we would appreciate it.

Mr. LAWRENCE. I am Richard Lawrence, Associate Director and Acting Medical Center Director today.

Mr. COLEY. I am John Coley, Chief of Engineering Service.

Mr. EDGAR. Tell us how long you have been here, too.

Mr. COLEY. This is my anniversary date. I have been here 3 years today.

Mr. KIRKPATRICK. I am Bill Kirkpatrick, Chief of Supply Service.

Mr. ALVARO. I am Tony Alvaro, Chief, Medical Administration Service. I have been here 33 years. Today is my anniversary date.

Dr. DE LAPENA. I am Dr. Erlinda De LaPena, Chief of Staff.

Mr. BANASSO. My name is Russell Banasso. I am the Administrative Assistant to the Chief of Staff, and if I am allowed to live until the July 7, I will have been here 35 years.

Mr. EDGAR. Thirty-three years and 35 years. The water must be good.

Richard, please begin.

STATEMENT OF RICHARD LAWRENCE, ASSOCIATE DIRECTOR, CLARKSBURG, WV, VAMC, ON BEHALF OF DAVID J. KILCOYNE, DIRECTOR

Mr. LAWRENCE. Mr. Chairman, members of the committee, I welcome you to the Louis A. Johnson VA Medical Center on behalf of the veterans we serve and our VA staff and volunteers, and particularly on behalf of Mr. David J. Kilcoyne, the medical center director. As you mentioned, Mr. Kilcoyne regrets his absence today because of notification last evening of a critically ill close family member in Wheeling, WV.

I would like to read for you a statement prepared for this hearing by Mr. Kilcoyne.

PREPARED STATEMENT OF DAVID J. KILCOYNE, VA MEDICAL CENTER DIRECTOR, CLARKSBURG, WV.

Mr. Chairman, members of the committee, initially may I express my appreciation at your kind invitation allowing me to submit relative, pertinent information on the Louis A. Johnson VA Medical Center in Clarksburg. We are part of Medical District 5, consisting of six VA Medical Centers, the other five being Altoona, Butler, Erie, Highland Drive, and University Drive, all in Pennsylvania. The District Director is Mr. Thomas Gigliotti of University Drive in Pittsburgh.

This medical center was opened for business on March 12, 1951, and since that time has served in a dedicated manner the 104,000 veterans in our medical center's service area. Originally, 110 employees began at this medical center, operating on a budget of $1.1 million, with an average daily census of 95 patients. Currently, there are 448 employees, treating an average of 6,000 patients a year, with an average current daily census of 188 patients and an operating budget of $17,961,000.

With 216 beds, the Clarksburg VA Medical Center is one of the most active affiliated hospitals of its size in the VA system. Our main cause of concern at this facility has been space deficiencies. Hopefully, this problem will soon be corrected.

We are pleased to note the Administrator of Veterans' Affairs, Harry N. Walters, has given approval for a facility improvement project at this medical center. It is anticipated there will be approximately 153 additional positions allotted for our medical center upon completion of the clinical addition.

There will be new and expanded programs in the inpatient-outpatient pharmacy, genito-urinary clinic, eye clinic, ENT clinic, cardiovascular laboratory, radiology, laboratory services, and outpatient mental hygiene and alcoholic treatment unit.

Our staffing is not considered at an optimum level. However, with our present staff, we feel we are able to provide quality patient care nonetheless.

There is every indication that we are as well staffed as the majority of similar type medical centers within the VA system. However, we do have problems when our average daily census is high, as it has been in the last few months, as a result of increased demands in providing compensation and pension exams and special services to Vietnam veterans, including Agent Orange, former POWs, and radiation exposure.

Our Regional Director is aware of our staffing and salary dollar needs and continuously attempts to provide resources when they become available within the system. Also, our Central Office officials have been intensely involved in establishing strategic planning methodologies for ensuring that all VA facilities have the necessary resources to provide the highest possible level of patient care. It is the goal of this endeavor to enhance the quality of care that is being delivered at the Clarksburg VAMC and all of the facilities in the VA system.

We also have difficulty in recruiting physicians, especially those in scarce medical specialties. This is primarily due to the fact that these physicians, in most cases, can earn a substantially greater income in private practice, and also somewhat due to the geographical location and economic condition of the area.

The Louis A. Johnson VA Medical Center has 25 non-VA nursing homes offering over 2,000 beds to this area. Although our present placements only represent 4.2 percent of beds available, the census continues to climb. If this trend continues, at the time of the next MEDIPP submission we will propose for consideration through the MEDIPP processing mechanism that a nursing home facility be constructed at this VA medical center.

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Provisions have been made to provide comprehensive health services to the female veteran and to ensure that high quality and equitable care is available to all female veterans presented to this facility.

With the proposed clinical addition and the approved renovation of a 43-bed medical ward, and the proposed renovation of a 43-bed surgical ward, a comprehensive health care delivery system will be available for the care of all female veterans and veterans in general.

The VA Medical Center, University Drive, Pittsburgh, is considered the tertiary medical care center within our district, and all veterans requiring specialized examination and treatment which are not available at this medical center are referred to them.

The projects submitted by this station and approved under the Congressional-initiated jobs bill were approved in the amount of $783,000. The bids received for these projects were lower than anticipated, resulting in a savings of $223,596. By direction of the VA Central Office, we were required to return these savings through the district to the region for distribution on other projects that had overruns due to high bids.

Mr. Chairman, I wish to take this opportunity to express my appreciation for your appearance at this medical center and for holding these hearings for the purpose of acquainting you in depth with the activities at this facility. The veterans of our service area have utilized this facility for the last 33 years. The center is well known, is highly respected, and has a great degree of acceptance not only in the community, but throughout the entire hospital service area. You pay us a great honor by appearing here and manifesting your continued support in providing health care to the veterans of this area.

Mr. LAWRENCE. I wish to thank you for the opportunity to appear before your committee.

Mr. EDGAR. Thank you very much.

I recognize that there are a number of other prepared statements. How many additional prepared statements do you have?

Mr. LAWRENCE. We have four others, sir.

Mr. EDGAR. I would be pleased to hear those statements at this time. If you would like to summarize or read your statement, it is up to you. The full text of your statement will be made a part of the record if you choose to summarize.

Dr. De LaPena.

STATEMENT OF DR. ERLINDA L. De LaPENA, CHIEF OF STAFF, CLARKSBURG, WV, VAMC

Dr. DE LAPENA. Mr. Chairman, members of the committee, please accept my sincere appreciation for the opportunity to be a witness on behalf of the Louis A. Johnson VA Medical Center.

I assumed the position of full-time Chief of Staff on December 25, 1983. Since that time, I am sure you are aware of the high workload which has been prevalent at this medical center and our staff's assistance in providing the necessary professional care for our patients.

Currently we have 15 full-time physicians, 2 temporary physicians, 1 part-time psychiatrist, 2 intermittent part-time temporary physicians, and 3 dentists on our professional staff. I wish to compliment the members of our professional staff for the outstanding job they are doing in providing the necessary professional expertise to care for our patients. This is noted in appreciation of their efforts in managing the heavy workload which has been prevalent at this center since the beginning of the fiscal year.

Our center is deeply involved in not only the care and treatment of the patients, but in teaching programs to ensure sufficient professionals who will assume responsibility for the ill, the aged, and

infirm veterans, not only to this medical center but throughout the north-central West Virginia area in the future.

Concurrent with this goal, we are affiliated with the West Virginia University School of Medicine, which provides surgical and dental residents to our center. In addition, a family practice residency program is ongoing in conjunction with the United Hospital Center here in Clarksburg. A physicians' assistant training program is also in effect in conjunction with an agreement with Alderson-Broaddus College in Philippi, WV. A student nurse training program functions under agreements with West Virginia Wesleyan College in Buckhannon, Alderson-Broaddus College in Philippi, and Salem College in Salem, WV. Sharing agreements are ongoing with United Hospital Center in Clarksburg and with the West Virginia University School of Medicine in Morgantown, WV.

To ensure needed round-the-clock coverage, 24-hour support service is provided by our centers' laboratory and radiology services. The general and comprehensive needs of our patients are currently being met at this medical center. However, due to the limitation of our staff specialities, clinical treatment cases involving sophisticated review processes and personnel are referred to our tertiary hospital at University Drive in Pittsburgh.

As I have mentioned earlier, there is an unusually high demand for the services of this medical center throughout our service area. Outstanding professional support is given our medical center through the utilization of daily consultants who visit our medical center from West Virginia University and by members of the Harrison County Medical Society.

The provision of service to our patients as mandated by law, however, has not been easy. Due to its geographical location, one of the biggest problems we have is the recruitment and retention of qualified physicians. Currently we are operating with a deficiency of five physicians on our professional staff. These include the following: one physician in the medical service, two physicians in the surgical service, one physician in the psychiatry service, and one physician in the pathology service.

The Congress has attempted to assist the VA in providing an incentive for physicians who would locate in remote geographical areas. We are currently paying a $2,000 per year bonus to attract physicians to this medical center. However, we still encounter difficulty in inducing physicians to come to this location.

It must be remembered the majority of physician applicants who would seek employment in the Veterans' Administration are those recently completing specialty training programs. The Veterans' Administration's competition with the outside sector is difficult because of the comparative potential for earnings. For that reason, when I stated earlier that our physicians are dedicated and hard working, please understand the sincerity and importance of my statement. It is only because we have the dedicated staff who currently serve that we are able to provide the quality of care given at this medical center.

I hope that we have been able to give you a brief general insight into the medical center. I appreciate the opportunity to testify here today and I will be ready to answer any questions the committee may ask.

Thank you.

Mr. EDGAR. Thank you very much for your statement.

Our next witness will be Anthony Alvaro, Chief, Medical Administration Service. The full text of your statement will be made a part of the record if you wish to summarize. Otherwise, you can read your statement.

STATEMENT OF ANTHONY D. ALVARO, CHIEF, MEDICAL ADMINISTRATION SERVICE, CLARKSBURG, WV, VAMC

Mr. ALVARO. What I have done, Mr. Congressman, summarizing would make it difficult because I have scattered a lot of these statistics throughout the whole statement. In fear of losing something, I would rather read the entire statement.

Mr. EDGAR. Please proceed.

Mr. ALVARO. I am Chief, Medical Administration Service, and, as such, I function in many capacities for management, the most important of which are that I act in an administrative advisory capacity to management, giving complete and concise information to assist top management in medical center operations.

One of the more important function I participate in for top management is serving on the district planning committee, with responsibility for strategic and operational field involvement on both the district and local level. District plans which result from this process will describe changes necessary to meet future health care needs in all elements of the Department of Medicine and Surgery in the VA.

I have administrative responsibility for medical administrative service programs. I direct and participate in bed utilization studies, analyses and evaluation. I coordinate all necessary information relating to bed demands, availability of staff and facilities, seasonal fluctuations, changes in procedures and policies as they all affect planned bed utilization.

I provide for the proper application of veteran laws relating to the determination of eligibility for hospitalization and domiciliary care and related services and benefits.

I provide for the administrative processing of admissions, discharges and transfers of patients, the furnishing of pre- and post-hospital care, and the disposition of deceased patients, their funds and effects. I evaluate patient and public attitudes toward the medical center as reflected in patient administrative areas, identify patient administrative policies and procedures with the public interest, and execute a program of action and service to earn patient and public understanding and acceptance.

I provide assistance and maintain liaison with county and State health agencies, private hospitals, service organizations, field officials, and private nursing home personnel. I work closely with county service officers in providing medical benefits to eligible veterans, participate in veterans' service officers training conferences, explaining and clarifying VA regulations governing medical benefits. I investigate complaints made by veterans to their congressional delegations and work closely with our congressional delegations in resolving same for management.

I develop and analyze meaningful workload figures which serve as the primary basis for the medical center budgetary allocations.

The Chief of Medical Administration Services coordinates and administers the outpatient programs, such as agent orange, compensation and pension exams, prisoner of war exams, outpatient care for fee-basis, service-connected veterans, and community nursing home programs and nursing home budgets, third party hospitalization, CHAMPVA, CHAMPUS, asbestos and employee examinations, and budget for fee-basis outreach.

Reference and comments on the above are as follows:

Agent orange: We were receiving daily complaints about too long a waiting period for examinations. We have administered 411 examinations and 25 followup examinations to date. In 1983, we were examining one patient per day and we are scheduling patients 3 months ahead.

We have accelerated our scheduled examinations to three to five per day. Now we are scheduled through April 2, 1984. To make this caseload current, our waiting time in the outpatient section increased from 58 minutes to 68 minutes processing time for other patients. Now we receive several complaints daily from veterans waiting too long.

To eliminate this problem, we either have to curtail the workload or add an additional physician in the outpatient area. It takes at least 1 hour of physician time, and approximately 1½ hours clinical support time, for each examination by the physician.

We would use 3 to 5 hours daily for agent orange cases alone. West Virginia has adopted an agent orange program which coincides with the Federal program which will create approximately another 4,000 to 5,000 more examinations in outpatient workload. They are beginning to come in now, and they have scheduled 16 this week.

We have no problem with compensation and pension examinations. We are scheduled through April 6 and current. Our POW examinations are current.

Our community nursing home program has increased from an average daily patient load of 55 last year to approximately 90 average daily census today. We have 28 on the waiting list at the present time. The waiting list is created from several different aspects of this. Mr. Lawrence mentioned the beds we have contracted for nursing homes, some 2,000, but we don't have access to all these beds. Some would rather not take on veterans and others want to screen the patients beforehand before they accept them in the nursing homes, thereby making us have an unnecessary waiting list at the present time. But if present patient load continues, we will exceed our funding by approximately $300,000 this fiscal year alone.

As additional funds are needed, they have been provided by our medical district. As nursing home needs continue to increase, we will review our plans for meeting these needs through the MEDIPP process. Our 1982 MEDIPP plan has been signed off and implementation is probably beginning this next week. But next week we will get into the 1984 plan. The 1983 plan has been initiated and submitted but it hasn't been approved yet.

The largest impact on outpatient workload, aside from agent orange examinations, has been the 84 percent increase in applications received from a given period in 1983 to the same period of 1984. Of this 84 percent increase, 82 percent of these applications were first-time applications for medical treatment. Our acceptance rate is about 85 percent. You can readily see why our average daily census [ADC] was 177 in fiscal year 1983 and went to an ADC of 198 for the same period in fiscal year 1984. The major problem about this increase, as far as we can see it, is probably due to the impact on our budget, because we are only budgeted for an ADC of 178 patients, thereby eating away at our resources.

During this period our length of stay increased from 10.2 to 13.9 days. We currently have a waiting list of 72 patients. Some of these patients have been on the waiting list for 2 months. We feel that this large increase in first-time applications is due to the economic conditions in this area. There have been applications submitted to other area hospitals to speed up this process, but they would rather not be transferred to other areas. They would rather remain in this area and be treated here and they would rather wait. So we generate letters every 30 days to these veterans, but none of them have elected to go to other hospitals. They want to come here.

Our outpatient waiting area is, at all times, in an extremely overcrowded condition. You can see for yourself today, if you went through up there, that we have them standing against the walls and sitting in chairs. Most times it is overflowing into the halls, such as it is today, with no seating available for them. Seating capacity in the outpatient waiting area is 49, with an additional 12 seats in the hall. We have recently taken steps, if there are any families accompanying the veterans into the outpatient area, we have them sit either in the auditorium or in the lobby of the hospital. Some of them would rather have their wives or next-of-kin with them because it is a pretty bad period when they're ill, but we have to instruct these family members to leave and wait somewhere else, where the patient himself would like to have some support from these families while he is waiting. But that has been stopped because we have no space for these families.

The average daily outpatient load Monday through Friday is 150 to 200 veterans, and most of these veterans are in the outpatient area for at least 2 hours.

Upon completion of our new facility, this overcrowding will be relieved because of a much larger waiting room area, separate clinic waiting rooms, and additional treatment rooms.

Due to funding limitations, we are not able to meet all of the demands for outpatient care. Nonservice-connected patients having the lowest priority for entry into the VA treatment program are being denied care consistent with law and regulations. They cannot understand why they are denied this service. For the most part, they are unemployed, out of unemployment benefits, and have no one to turn to for help. They inquire for the first time at this facility and we turn them away, telling them they are not eligible. They feel that this center only serves certain veterans and why should we call this a veterans' center. These veterans are, for the first time, asking for help, and we now turn them away.

There are some stat sheets attached to my statement, some statistics on alcohol treatment, which is important to this center. I have made it a part of my statement.

In 1982 we had a total of 616 diagnosed with alcohol. Of these 616, 201 of these were primary alcoholic diagnosis, for which they were primarily treated and created the largest length of stay.

In 1983, we have had 549 to date, and of these 549, 324 of these were primarily diagnosed. So statistically you can see that in 1982 probably 25 percent were diagnosed as alcoholism, and now we're looking at 50 percent of our workload that has been for alcoholism, 50 percent that are primary and causing a great length of stay. Of these 324, we made referrals on 43 to other hospitals. Of these 43 that we have made referrals, only 6 of them participated in the program.

I also appreciate the opportunity of appearing before your committee and I would be glad to answer any questions you have.

Mr. EDGAR. Thank you very much.

Mr. John Coley.

STATEMENT OF JOHN H. COLEY, JR., CHIEF, ENGINEERING SERVICE, CLARKSBURG, WV, VAMC

Mr. COLEY. Mr. Chairman, members of the committee. I think I will read what I have presented to you. However, I would like to add something to it. That is, one of the first questions I am always asked when I tell somebody what I do, which is chief of engineering at a VA medical center, they always come back and say "Why do you need an engineer at a medical center?" The VA was one of the forerunners in requiring graduate engineers to run their engineering services. Community hospitals are requiring it now because of the cost of equipment and the need for proper maintenance. So there is an engineering service at each VA medical center.

Some of the things that we do to support the VA medical center include:

Preventive maintenance and repair of all direct patient care biomedical equipment, such as x ray, UCU monitors, blood and gas analyzers, and defibrillators.

Second, we also have preventive maintenance and repair of all building service equipment and personal property which includes such items as medical air systems, vacuum systems, gas and steam sterilizers, electrical systems, air-conditioning systems, and steam heating systems.

We provide grounds maintenance for the entire facility. This includes mowing grass, trimming trees, removing snow, and any other work necessary to provide a safe and pleasing area for the veterans.

Project development and control is a primary function of engineering service. As needs are identified at this medical center, engineering service develops the necessary design criteria which may then be designed in-house or awarded to an architect engineer design firm. During the design stage, we review all drawings and coordinate with the requesting service. When construction begins, engineering is the technical representative for the contracting officer. We advise the contracting officer as to the technical accept-

ance of the work being performed. The review and approval of all materials used in each project is performed by engineering service, as well as monitoring contract compliance in all other areas.

The operations function of Engineering Service, with the use of three vans, provides transportation for veterans to West Virginia University Medical Center, the Pittsburgh VA Medical Center, Washington VA Medical Center, and other health care facilities, as required.

We also deliver oxygen to approximately 31 veterans who are medically required to keep oxygen in their homes. As part of operations, we provide steam to the medical center with three 223 horsepower, gas-fired boilers, and provide air-conditioning with two 300 horsepower electrically powered chillers.

The medical center safety program is a function of engineering service. The chief engineer is the designated safety officer and is responsible for inspection, identification, and correction of noted safety violations. The safety laws, as prescribed by OSHA and the VA, must be interpreted and applied to maintain a safe environment for patients, visitors, and employees.

The maintenance requirements are expanding each year. In order to maintain the level of maintenance required, we must contract out approximately $120,000 of equipment maintenance in high-tech areas, such as computerized analyzers, sophisticated monitoring equipment, and diagnostic equipment. We have two full-time employees in the biomedical shop who are technically qualified to perform the above work.

Existing staffing in Engineering Service consists of a total of 30 employees. Six of these are required for the 24-hour operation of the boiler plant. In the area of maintenance, we have two air-conditioning mechanics, two electricians, one pipefitter, one plumber, one carpenter, one carpenter-worker, one mason, one painter, one gardener, and one maintenance foreman. We also have four vehicle operators to provide transportation to veterans on a daily basis and to deliver oxygen. As previously mentioned, we also have two technicians in the biomedical section.

There are two graduate engineers, the chief and assistant chief, who provide technical advice in all of the areas for which engineering is responsible. We have one engineering technican whose primary responsibility is project development and monitoring. The remaining three positions include a secretary, clerk typist, and work order coordinating clerk who are necessary to monitor the engineering budget which was over $1.5 million for fiscal year 1984, the work order system, and the extensive reporting required of engineering service.

The construction program at this facility has been very active during the past 2 years, and will continue to be very active in the future. In fiscal year 1982, the total obligations for construction contracts amounted to $357,538. During fiscal year 1983, a total of $1,480,500 was obligated at this medical center, of which $579,000 was funded by the jobs bill. The approved projects for fiscal year 1984 total $3,515,000, which includes ward 3A renovation. I feel the above numbers are impressive for the size of facility which we have here at Clarksburg.

The design and obligation of each project represents a lot of work, but it is only the beginning. One of my primary concerns is that we receive the value for the money we spend. To assure we do get what we pay for, we must monitor each project as closely as possible. The low bid process used by the Government gives almost no option when faced with a contractor with a poor record, and there are times that a small project may require enormous amounts of time to monitor properly.

The technician inspecting the job, the resident engineer, and the contracting officer must always work together to assure that the Veterans' Administration receives what it has specified. The increase in the projects at this facility has not led to an increase in staffing.

I am proud of the project administration at this facility. As the total dollars indicate, we have had a tremendous workload increase, especially since most projects overlap into the next fiscal year. The recent jobs bill projects and the projects approved for fiscal year 1983 and fiscal year 1984 have resulted in funding all the projects on our nonrecurring project listing. Our 5-year plan provides a method of coordinating our need with MEDIPP planning. This planning process allows each facility to schedule their projects to meet the established district needs. All the projects submitted by this facility are required to correspond to the trends and programs as established by MEDIPP.

MEDIPP concurs with the approved clinical addition for this facility. The new addition has been approved for fiscal year 1985 with design of working drawings beginning in October 1984. If design funds would become available immediately, we could begin working drawings in July 1984, and begin construction in July 1985, which would advance the project by approximately 6 months.

The clinical addition will consist of new construction and renovation of existing space. The new construction will be a three-story building attached to the south end of the medical center. The new construction will add 61,749 net square feet to our facility, and will renovate 31,648 net square feet of existing space. The final preliminary drawings of the clinical addition are available for your review at the table to my right.

Our existing space needs are critical at this facility, and the new addition will allow corrections of the many space deficiencies that now exist and have been identified by previous JCAH inspections.

I thank you for the opportunity to submit the information concerning engineering at this facility to the committee.

Mr. EDGAR. Thank you, Mr. Coley.

Mr. William Kirkpatrick.

STATEMENT OF WILLIAM T. KIRKPATRICK, CHIEF, SUPPLY SERVICE, ACCOMPANIED BY RUSSEL BANASSO, ADMINISTRATIVE ASSISTANT TO THE CHIEF OF STAFF, CLARKSBURG, WV, VAMC

Mr. KIRKPATRICK. Mr. Chairman, members of the committee: The responsibilities of the Supply Service may best be described as providing necessary supplies, equipment and services to areas of need

at this medical center as quickly, efficiently, and economically as conditions permit.

Supply is a service organization. At this medical center it is staffed by 18 persons. These individuals are assigned to responsibilities in the areas of purchasing and contracting, which has four employees; property management, four employees; processing and distribution, or the Central Service, five employees; storage and distribution, the warehouse, three employees; and my office, which consists of a secretary and myself.

Each activity lends itself to an area of expertise that is totally separated from, yet directly interrelated, with each of the others and to the overall patient care mission of the medical center.

Based on work rate standards established by our central office, the service is understaffed in relation to the work produced. The most recent measurement of statistics indicated an overall effectiveness of 134.4 percent. A Supply Service technical survey conducted February 6 to the 10th of this year reported—and I quote:

> The Supply Service at VAMC Clarksburg, WV is staffed by a small group of dedicated and highly conscientious individuals who perform with limited resources. Considering the limitations, they provide outstanding support to management and to using services.

The quality of our staffing is excellent. A major problem with which we must deal on a daily basis is insufficient space. This condition exists in the warehouse and in the processing and distribution area. We must operate in approximately 50 percent of the recommended space requirements. This severely restricts the service we might otherwise be able to provide. It is anticipated this deficiency will be corrected with the completion of the clinical addition. However, it should be noted that insufficient storage capability during the construction period could impair the completion of that project unless additional space can be made available.

Procurement of equipment is another responsibility of this office. Neither replacement nor additional equipment funds keep pace with perceived needs. We were provided $100,393 in fiscal year 1983 for replacement equipment, and $94,635 in fiscal year 1984. This level of funding allows us to meet only our highest priority needs. Additional equipment funding for fiscal year 1983 was $83,390, and for fiscal year 1984 it was only $58,002. Again, this funding will meet only our highest priority needs.

It is noted that all purchasing activities are controlled by Veterans' Administration and Federal regulations. For example, all purchases are considered as suitable for award to small business and/or labor surplus area concerns. All proposed procurement for construction anticipated to cost between $2,000 and $1 million will be considered as though the Small Business Administration had initiated a set-aside request. Determinations to deviate from this policy will require review by the director of small and disadvantaged small business.

Contracts with the Small Business Administration, who in turn enters into subcontracts with eligible 8(a) or minority concerns, are encouraged. All competitive and noncompetitive procurement actions of $10,000 and above are published in the Commerce Business Daily at least 10 days before the issue date of the solicitation.

Competition is encouraged on all procurements and documented competition is required on all purchases in excess of $500. Federal and Veterans' Administration regulations and law, while time consuming, assure that all procurement accomplished is done so as economically as possible and that there is a fair and equitable distribution of procurement dollars. All procurement activities are under continuous internal and external reviews to assure the integrity of the system.

Mr. Chairman, the total supply activity at this medical center has, within the past 12 months, been reviewed by the Joint Commission of Accreditation of Hospitals, systematic external reviews, VA Inspector General staff audit, and supply service technical visits, and I am pleased to report no serious deficiencies were noted.

Thank you for the opportunity to appear before your committee.

Mr. EDGAR. Thank you very much. All of your statements were very thorough and I think we have at least a sense of the medical center here and what its strength are, as well as some of its problems.

I have a number of questions that I would like to pose to all of you on the panel, but I am going to yield my initial time to Congressman Mollohan who will begin the questioning.

Mr. MOLLOHAN. Thank you, Mr. Chairman.

I would like to also thank the panel for their thorough statements. I think that gives us an excellent overview of the facility.

I would like to touch first on the clinical addition. I think your statements have impressed upon us the necessity for the addition and the fact, that it is absolutely essential for the continued service of the veterans. You were very thorough in describing this need. Mr. Coley also touched on what we might be able to gain by accelerating the addition by having money in the fund allocated for architect and engineering work. I am very interested in that and have been working very hard on the committee with the chairman and also the Veterans' Administration to ensure that the clinical addition is a candidate for the advanced funding at the first opportunity it becomes available. I would like to clarify the timing of that, though, if I may.

As I understand it, if we do not get an appropriation before fiscal year 1985, which would be October, then we will not be able to do any architect or engineering work or ground preparation work until, at the earliest, that date. Is that correct?

Mr. COLEY. It sounds like some dead time in there. Say we get it funded in October this year, and yet we won't start for several months pending negotiation with the architectural/engineering firm. If we would get funding now, we would only save 6 months.

Mr. MOLLOHAN. OK. But my question is just a bit different. It's very precise.

If we do not get the accelerated funding—in other words, if we don't get money out of this general fund during this fiscal year—then we won't be able to spend any money on this project until October 1985, assuming it's appropriated; is that correct?

Mr. COLEY. October 1984.

Mr. MOLLOHAN. I'm sorry.

Mr. COLEY. Fiscal year 1985.

Mr. MOLLOHAN. That's correct, October 1984, fiscal year of 1985.

Mr. COLEY. Right.

Mr. MOLLOHAN. If we are abie to get that funding, we could start whatever we're going to start immediately after getting the funding and, therefore, would be able to do something in this fiscal year, in fiscal year 1984?

Mr. COLEY. Yes, sir. Unfortunately, the way it is set up, there is a year lag in there, which you are aware of, that without some help we can't do anything in that time period.

Mr. MOLLOHAN. So we're just sitting in the water dead, aren't we, right now?

Mr. COLEY. Yes, sir.

Mr. MOLLOHAN. I just want to commit to you my efforts and energy to get allocation of that money accelerated. I know you all are stressing through your chain of command the importance of doing that, so we are working together. Chairman Edgar has been very helpful, as a matter of fact, during the last year in reinforcing my communication with the Veterans' Administration on that issue, which we appreciate, because as he is aware of first-hand now, we have a great need here.

I would like to touch a bit on the aging veteran, which we have been impressed with, I think, on two occasions today, in the Martinsburg facility and here today. It is apparent that that's where the greatest need is going to be.

I would like to know what we are doing at the hospital in planning with the Veterans' Administration to prepare for that. I think to give us a handle on it it would be good to discuss what kind of numbers we are talking about.

Mr. Alvaro, maybe you could speak to that.

Mr. ALVARO. Well, if we would talk about the processes of MEDIPP again, our 1982 MEDIPP plan was approved and this is what that plan has in store for Clarksburg for the aging veteran.

[Subsequently, the Veterans' Administration furnished the following information:]

To determine the inpact of this aging veteran population on our medical center so that we will able to provide for their needs, the following goals have been set by MEDIPP for our aging veteran population:

For 1985: Geriatric Education Program; hospice; respite care; participation in Community Service Adult Centers; and encourage participation in geriatric and gerontology with West Virginia University.

For 1987: Establish a Geriatric Day Treatment Care Center. Also, there is an additional plan to provide 30 intermediate care beds with the new clinical addition.

Mr. MOLLOHAN. Let me do this, Mr. Alvaro. Excuse me for interrupting you.

What I wanted to do was get some numbers on the table. What kind of increases are we looking at in the aging veterans category? What can we expect into the future?

Mr. ALVARO. In 1985 and 1990, in 1985 we are presently dealing with almost 17 percent of our load being over the age of 65. We will be looking at an increase in 1990 of probably 28 percent of our load, and probably in the year 2000, if nothing ever occurs to enable us to have more veterans, we will probably be looking at 32 percent of the whole VA population load throughout the country.

Mr. MOLLOHAN. Right now how are we handling, for example, nursing care needs? How is this hospital dealing with that? You don't have a nursing home here, I understand that.

Mr. ALVARO. No. At the present time we have 90 nursing placements in the northern district of West Virginia, and we also have 28 on the waiting list. Some of these are in dire need of real skilled care, which some nursing homes wouldn't even touch because of their health conditions. There are no nursing home beds available, especially in the eastern part of our State.

Mr. MOLLOHAN. Do you expect those numbers to increase?

Mr. ALVARO. They have doubled. We began with 55 in 1983, and we presently have 90 in nursing homes and 28 on the waiting list. We began with the budget of $900,000 that we were given in 1982, and we're looking at probably $1,300,000 this year. We go to the district and the region for that funding, and we have been able to get that money for them up to this point.

Mr. MOLLOHAN. In order to pay for the private home placements?

Mr. ALVARO. In order to pay for private nursing home placements.

Mr. MOLLOHAN. What was your budget for, say, 1984 for private home placements for senior veterans?

Mr. ALVARO. We would be looking at the same thing. Probably $950,000.

Mr. MOLLOHAN. How many veterans were you planning on serving?

Mr. ALVARO. We were planning on an average daily census [ADC] of 65.

Mr. MOLLOHAN. And how many are you serving?

Mr. ALVARO. Right now we have 90 out ADC, regular workload, daily, plus 28 waiting for homes.

Mr. MOLLOHAN. From the time that you planned on your need until today you had a tremendous increase in demand, obviously.

Mr. ALVARO. The increase in demand was that we doubled our applications in this hospital in the past months.

Mr. MOLLOHAN. Are you getting funding to take care of those placements?

Mr. ALVARO. We go in and ask for funding, and we have been able to get it from the medical district and the region.

Mr. MOLLOHAN. Is the fact that you have 28 people on the waiting list a reflection that you're not getting as much funding as you need?

Mr. ALVARO. That we can't—I don't think the biggest part of the problem is with the money. The problem is there is no bed resource for us. We need more skilled community nursing home beds——

Mr. MOLLOHAN. You're beginning to exhaust the capacity even in the private sector to absorb these veterans?

Mr. ALVARO. Yes. We have 2,000 beds. Twenty-eight are waiting for bed placement. There are no beds out there in the northern West Virginia area at this point.

Mr. MOLLOHAN. Not going into it any deeper than I have, that would suggest to me that there is an internal need to begin addressing this. I wonder if maybe in the MEDIPP mechanism that is being started.

Mr. ALVARO. Part of that MEDIPP planning for this hospital, for this district will be discussed, on the 25th and 26th. We're going to Pittsburgh and we will go over the 1983 submission of MEDIPP. The 1982 MEDIPP has already been approved. We are going to go through 1983, the implementation dates, and then we're going to initiate probably some charges to the task force for 1984 for two things that I'm going to place on the agenda, which is the need for a nursing home in this area, if at all possible, and second, would be for an alcoholic ATU unit within our new clinical facility.

Mr. MOLLOHAN. I would like to talk about that alcohol unit in just a second. But I appreciate your bringing out those numbers and I would like to commit to you my interest in doing that. What you are saying confirms what the numbers suggested to me, that there is an astronomically growing need. As I understand it, in 1981 the 65 and over veterans population was 9.2 percent of the total veterans population in district 5, and by the year 2000 28 percent of our veterans will be over age 65.

Mr. ALVARO. That's true, up to 30 percent in the year 2000. The part you are looking at, those in need, it is not only the aging veteran but the disabled veteran who has been disabled for a period of time and who is under 65 that are placed in nursing homes.

Mr. MOLLOHAN. I appreciate those comments. Does anybody else on the panel have comments with regard to that? I guess in the interest of time we have good information on that.

Mr. EDGAR. Would the gentleman yield on this question of the aging veterans?

Mr. MOLLOHAN. Certainly.

Mr. EDGAR. Obviously we have a problem nationally. We presently have 3.3 million veterans who are aged 65 or older, and in the next 6 years we will have 7.7 million veterans, by the year 2000, who will be 65 or older. More than half of the American males 65 and older in the year 1990 will be veterans. Pressure on the system increases with that age.

What kinds of things are you doing, apart from the physical planning of a nursing home? I want you to know that I share the concern of Congressman Mollohan to see that included in the 5-year plan quickly so that this area can have a nursing home. However, even if you put that 120-bed nursing home in place, wave all the magic wands and have it next door and open for service within, let's say, a year-and-a-half or 2 years, which is not possible——

Mr. MOLLOHAN. That sounds good, Mr. Chairman.

Mr. EDGAR. But let's just say that occurred. Given the numbers that the Congressman has shared, and given the percentages that you have shared, that's not going to meet the need. If your numbers are going to double, triple, quadruple, over the next 10-year period, and your physical plants aren't going to double, triple and quadruple over that same 10-year period, you're not going to make it.

So the question I have is, what contingency plan is this facility making for things like home health care, noninstitutionalized settings; what work are you doing with the community and neighborhood groups; is there a plan for a second State veterans nursing home in the State of West Virginia, where 65 percent of the construction can be funded by the Federal Government and 35 percent

by State government, so that we could share that responsibility for aging veterans? What other things are you planning as the staff of this hospital, who knows where needs are going to occur?

Mr. Lawrence, do you want to tackle that?

Mr. LAWRENCE. Yes, sir. In the clinical addition there is a 37-bed intermediate care ward which recognizes the fact that we will have the aging veteran coming in in increasing numbers there. Presently, of course, we have none of those beds and have to rely solely on nursing home beds. This is one step that has been taken under the MEDIPP process.

Others include setting up day treatment programs here at the facility. The emphasis on geriatric education——

Mr. EDGAR. Could you use an adult day care center, for example, where veterans could be brought on a daily basis to a facility for care and treatment and then taken home at night? Would that alleviate the pressure? I'm asking you to be imaginative in terms of how to deal with this issue.

Mr. LAWRENCE. Yes, and we are hoping to do that right in this auditorium. We have a project for making some of this space multipurpose space, in which we can close off part of it and open it up again as needed for patient activities. But here we would be able to provide veterans some support from their homes here at the medical center.

There will be other programs developed under the MEDIPP process. The emphasis on geriatric day care treatment is probably one that will be entertained greatly in the MEDIPP process in the meeting that Tony mentioned 2 weeks from now, and in future meetings.

Mr. EDGAR. Do you ever have a staff meeting where you get everybody together, nurses, physicians, administrators, just to sit down and "shoot the breeze" over this aging veteran problem and speculate that if we had the ability to throw a few dollars at some imaginative direction, here's what we might do?

Mr. LAWRENCE. This process that you describe did take place in our implementation plan development under MEDIPP. We had ad hoc groups, multidisciplinary groups, that came together and just sat down and "what do we need to do; what are we talking about; what are the definitions now." Some of these terms initially were unfamiliar to us. We hadn't been concerned about the hospice, palliative care, the things that will be necessary as the patients age. Now our staff is very familiar with these terms and will become more so as we talk more about it.

Mr. EDGAR. Mr. Alvaro has something he would like to say.

Mr. ALVARO. I just want to throw some light on this. When you say geriatric and nursing skills, you're familiar that there is a difference in nursing patients. One is that we plan a 30-bed intermediate care unit here in our new facility. We have right now 70 equivalent geriatrics out in the community. We plan to have 30 beds and we have 70 out in the community. Of those 90, 70 of them are intermediates, what you would consider intermediates. The State homes, for the most part, you're looking at domiciliary for the most part that takes those patients. We have had——

Mr. EDGAR. Not necessarily. I know in this State presently it is domiciliary, but in Pennsylvania——

Mr. ALVARO. In Pennsylvania they plan on using 14 or 16 percent of the bed availability, but West Virginia doesn't have that. Of all the referrals we sent to Barbersville, we had one person that agreed to go down there when it first opened. I don't know how many there are now. You probably would have to talk to the West Virginia Department of Veterans Affairs, but I think there's probably well over 100 patients there now. It's a different type of patient. It's a patient that can clothe and feed himself and ambulate. Skilled nursing home patients cannot ambulate, feed and clothe themselves and that is why the 30 beds will not cover our skilled nursing home patients.

Mr. EDGAR. We understand that. The point that I was making is that a State home doesn't have to be a domiciliary care facility. It can be a nursing home facility. This State doesn't happen to have that, but it could, and we are trying to encourage the Office of Management and Budget to double its commitment for State veterans nursing homes. I, personally, as the Chair of this subcommittee, am encouraging the States to put applications in for additional nursing home facilities which are Federal-State partnerships, because the Federal Government isn't going to meet the need soon enough for those veterans. It is one piece of this whole puzzle.

I guess what my concern is—and I appreciate your planning and what you're doing—just to try to stimulate you a little bit, to say if you had all the money in the world, you would have a nursing home, you would have a geriatric research center, you would have extended care, you would have some physicians and nurses on board, who are trained and skilled in that whole area of geriatric care. That's what we're going to move toward.

In the interim, and beyond the construction of those institutional facilities, there are all kinds of home health care delivery systems and shared facilities. We have discovered, through our visits, something called respite care which we think is an exciting concept. Certain beds are set aside to take a veteran patient for a weekend or a week, to free up the family caring for that veteran so that they can get some rest and come back renewed to provide the three meals a day and the total care that the veteran needs.

As we find ourselves in more of a crunch, there are going to be more veterans who will be placed back in their own homes for care. What can we do to get community nursing services geared up to help the veterans; what can we do in terms of adult day care centers and other facilities. You have been very kind to deal with that.

Let me yield back to my colleague, Mr. Mollohan.

Mr. ALVARO. The MEDIPP plan charges were sent out for long-term care nursing. Charges went out for social work, and they came back with hospice, respite, and they are in our 5-year plan.

In 1985, establish geriatric patient education; in 1985, university education for specialized geriatrics; in 1985, elderly veterans participation in community social activities; in 1985, hospice philosophy on care of the aging veteran, physical facilities and patient care; in 1985, a day care center; in 1985, a respite care program established with the Clarksburg VA medical center; by 1986, establish a satellite EEG station—these are only five charges made in the MEDIPP toward that aging veteran. So they are all in place.

The need at this point, what has happened to us in the last year, year-and-a-half, we are in dire need of nursing beds, skilled nursing beds, and intermediate beds in a new facility wouldn't care for that nursing patient, really. It would be somewhat of an intermediate bed rather than nursing bed.

Mr. EDGAR. I wish the MEDIPP plan deadlines for 1985 were accurate. My guess is that you will establish some of those programs, but I'm not confident that there will be enough dollars made available to all the facilities who want to establish such programs by 1985. You know, we're 20 years late with things like hospice care. That's not a new concept. It is something when I was in theological school we were studying as part of our pastoral psychiatry courses, where Kubla, Ross and others were doing research on that in terms of death and dying a long time ago. We think of it as a new thing and it's not so new.

I yield to my colleague.

Mr. MOLLOHAN. Thank you very much, Mr. Chairman.

I would like to inquire about our capability at the facility to treat alcoholic problems. What is the current capability at the hospital for treating alcoholism? Anybody.

Dr. DE LAPENA. For the acute alcoholics, they are admitted under our medical service and taken care of. For the long-term process of rehabilitation, they are referred to our tertiary hospital in Pittsburgh, at Highland Drive.

Mr. MOLLOHAN. Can you give us an idea of what the scope of the problem is, how many patients you have with this kind of a problem, and how many of them do you treat and how many of them do you not treat?

Dr. DE LAPENA. From Mr. Alvaro's statistics, in 1983 the primary diagnosis of alcoholism was 324 cases, which was 50 percent of total admissions.

Mr. MOLLOHAN. What does the trend line look like? How does that compare with previous years?

Mr. ALVARO. We were looking at 12 percent before, the diagnosis with alcoholic entities in it, and now we're looking at over 50 percent. It has increased twice in a year-and-a-half actually. We have had 600 discharges with alcoholism in their diagnosis. Out of those 600, 324 of them were primary alcoholics; 24 were referred on to other alcohol treatment units; 2 refused to go anywhere. About 12 percent of our load right now includes alcoholism in its diagnosis.

Mr. MOLLOHAN. That's 1982.

Mr. ALVARO. In 1983, we admitted something like 600 patients with over 50-percent primary alcoholic diagnosis.

Mr. MOLLOHAN. When you say primary alcoholic diagnosis——

Mr. ALVARO. The No. 1 diagnosis for which he was treated.

Mr. MOLLOHAN. You mean he came to this hospital——

Mr. ALVARO. He came to this hospital to be detoxed and treated under some type of alcoholic program.

Mr. MOLLOHAN. Out of that 324, can you give us an idea of how you treated them?

Mr. ALVARO. Sixty percent were readmitted and 23 were referred to the ATU, of which we have 14 back here, that didn't even complete their ATU stay in the Pittsburgh hospitals.

Mr. MOLLOHAN. How many does that mean that you turned away without treating?

Mr. ALVARO. Last year we probably turned away 80 percent, 20 percent with treatment followup.

Mr. MOLLOHAN. You turned away 80 percent?

Mr. ALVARO. We didn't turn them away. I mean, we have no treatment here available for them. We referred 24 to the unit, the Pittsburgh unit, the ATU at Highland Drive in Pittsburgh.

Mr. MOLLOHAN. For whatever reason, though, as much as 80 percent of that group that came here for——

Mr. ALVARO. Eighty percent of our alcoholic patients——

Mr. MOLLOHAN. Were not treated?

Mr. ALVARO. I would say probably 90 percent of alcoholic patients are never treated as follow up visits. They are usually readmitted with alcoholic diagnosis.

Mr. MOLLOHAN. What is the problem and how should we address it?

Mr. ALVARO. A lot of them are referred over to the ATU in Pittsburgh. They screen them and give us—they tell us the ones they will accept and the ones they won't. There was something like 43 referrals, 41 of these were referred to Pittsburgh.

Mr. MOLLOHAN. Would the problem as you describe it suggest that an additional facility to solely treat the alcoholic-drug problem be worthwhile or justified here?

Mr. ALVARO. In my personal opinion, an ATU here would serve a great need in this area.

Mr. MOLLOHAN. Would you describe it as a growing problem?

Mr. ALVARO. It is a growing problem. We went from 12 percent to 50 percent in this area.

Mr. MOLLOHAN. Is this something you would address in your MEDIPP planning?

Mr. ALVARO. Yes, it is addressed in the MEDIPP plan.

Mr. LAWRENCE. I might mention, Congressman Mollohan, that the clinical addition has an outpatient ATU program coming with it.

Mr. MOLLOHAN. I'm sorry?

Mr. LAWRENCE. Our clinical addition has an outpatient ATU coming with it, so with that we will be able to support the patients better as they come back from organized programs, wherever they may enroll in those programs. They can get the followup needed here locally.

Mr. EDGAR. What is the reason for the increase in alcoholism in this particular area? Is it long-term unemployment, is it something other than that?

Mr. ALVARO. We doubled our applications in 1 year of patients seeking this hospital for the first time, and of the——

Mr. EDGAR. But the question is, What is the reason? I'm guessing at long-term unemployment.

Mr. ALVARO. The reason, when you bring in twice the patient load you're looking at, you're doubling your alcoholic conditions.

Mr. EDGAR. No, no. I am asking why is there an increase of people who are alcoholics? Is the drinking tasting better?

Mr. ALVARO. No. I think it's the increase when you double your applications. Say you have——

Mr. EDGAR. I don't understand what you're saying.

Mr. ALVARO. The first time applications we are seeing, they're doubling, the applications for hospitalization.

Mr. EDGAR. And I'm asking why. Why are the applications doubling?

Mr. ALVARO. Probably the economic——

Mr. EDGAR. Tell me why twice as many people are now coming to your door.

Mr. ALVARO. Because we've got 17.4-percent unemployment out there. I guess that's why.

Mr. EDGAR. That's the question I am asking. OK.

Mr. ALVARO. The veterans are using this for the first time; 84 percent of our walk-in applicants are first-time users.

Mr. EDGAR. Is it also that not only do you have long-term unemployment, but the veterans who are long-term unemployed are now off unemployment compensation based on their at their former employment?

Mr. ALVARO. They have been through the extended unemployment for the most part and without any resources at all.

Mr. EDGAR. Is there anything in the Veterans' Administration's central office, or regional office, that triggers any special dispensation for this particular hospital, in an area of high long-term unemployment where you see catastrophic increases in the percentage of alcoholism, and long-term unemployed veterans using this as their primary health care mode?

Mr. ALVARO. There is nothing there in the central office.

[Subsequently, the Veterans' Administration provided the following clarifying information:]

There is no mechanism for triggering a "special dispensation." However, there is a management process by which resource adjustments can be made for a medical center which is facing unusual or unanticipated demands for services.

Mr. EDGAR. Isn't that a lack in the system, because in certain parts of the country with low unemployment, you may have a larger number of aging veterans, a larger number of certain kinds of veterans, but their use of the system may, in fact, be lower because they don't have that unemployment pressure?

Mr. ALVARO. For the most part I think the factories around here, the ones that were working before, had some type of alcoholic program and they all accepted it. But with unemployment comes no treatment for alcoholism and those are the ones we're seeing for the first time.

Mr. EDGAR. Thank you.

Mr. Staggers.

Mr. MOLLOHAN. Can I just ask one followup question?

Mr. EDGAR. I yield the gentleman 1 additional minute.

Mr. MOLLOHAN. Thank you, Mr. Chairman.

Just to follow upon what the chairman asked, you are communicating this problem—and I suppose it is communicated just in the statistics you send forward—and you are asking for relief. What kind of response do you get from the VA central office on that?

Mr. ALVARO. The response we get is in MEDIPP we're gearing toward that end. We are looking at percentages, we're studying them, we'll be studying them again in 2 weeks——

Mr. MOLLOHAN. But you have an immediate problem that's chronic.

Mr. ALVARO. It is more so the problem with the veteran. At the present time we can place those veterans like in Highland Drive or Chillicothe, Martinsburg.

Mr. MOLLOHAN. So their response is "send them to Pittsburgh"?

Mr. ALVARO. Their response is, in the district we have that ATU and we have to use that.

Mr. MOLLOHAN. But what you have said here, as I understand, is that that has not been satisfactory, for whatever reason, either because the veteran doesn't want to go that far or whatever, that need is not being met, even though there might be a Highland Drive or whatever?

Mr. ALVARO. That's true.

Mr. MOLLOHAN. Thank you, Mr. Chairman.

Mr. EDGAR. I yield to my colleague.

Mr. STAGGERS. Thank you, Mr. Chairman.

I don't want to beat a dead horse, but I would like to also speak to the aging veterans. I would agree with the chairman, that if we don't do something now, we're going to faced with it in the future. I think what we are looking to you for is some guidance in how you perceive we could deal with that. I appreciate the chairman trying to prod you along and asking for your ideas. I think it is going to be an important thing. It is one of those problems, I guess, if we ignore it long enough, maybe it will go away, if we don't provide the facilities. But I don't think that is good for the veterans and I don't think that's what Congress wants to do. So I am concerned about that.

In listening to the testimony, it would appear that there are basically four problems. Mr. Kirkpatrick talked about the understaffing and equipment, and I would assume that's probably a money-type of problem. It is not that you haven't requested the staffing or the updated equipment, but the money is not really available. There are two other areas, though, the spacing. It appeared in a lot of the testimony about the lack of space.

Will this be cleared up with some of the things we're trying to do? I'll open that up to anyone. Are you going to continue to have a space problem here at the VA facility?

Mr. LAWRENCE. Well, we hate to say that the clinical addition is the panacea for all our troubles, but it will be. We will have almost as much space as we currently have again in the clinical addition. With that, we will be able to move some programs that are crowded in this facility into the additional space, and then use the existing space for stretching out, if you will. At the same time we will be taking on more sophisticated programs that we don't presently have. So with the 153 staff that will be coming with that, we will get some much needed relief there, space and personnel-wise.

We are a small facility. A small facility suffers from not having the depth of staff. As Mr. Coley explained, he have one carpenter, one mason, one plumber, that type of thing. As we become a larger facility, we will be able to develop that depth of staff, so we look forward to that clinical addition very much.

Mr. STAGGERS. With that addition you're not anticipating any inherent weaknesses that we're going to have to address even with

that? I understand that you can't foresee everything in the future, but you do reasonably expect that that will cure most of the problems?

Mr. LAWRENCE. I think there has been some good planning in this. Of course, the new facility has been talked about for a number of years here. Through the years, as new ideas have come in, they have been incorporated into the preliminary planning.

Now, this clinical addition, of course, is based on projections made on population statistics, the number of veterans in our catchment area, and at the time we get there we should be in a very much expanded mode to meet many of the problems that we currently have.

I think our central office is supportive of our needs. We are in a situation of very high unemployment. Hopefully this won't continue to exist. But still there will be the other needs, as you have emphasized, the aging veteran and so on will require these additional programs and the extra space.

Mr. STAGGERS. I hope so, also. I was hoping there was no inherent weaknesses.

One other area that was addressed, and I believe the doctor addressed this, about the recruitment of doctors. It seems a shame to me, that with three medical schools in West Virginia, that we are facing the possibility of not being able to attract West Virginians to stay in the State and to come into facilities such as the VA.

Is there a particular group of medical students, such as West Virginians, such as West Virginians from rural areas, that have historically stayed in the area or who have historically come into the VA system, that we should encourage into the medical schools.

Dr. DE LAPENA. The medical students from West Virginia are coming back into West Virginia, but they are practicing outside. As I indicated earlier, the competition, the salary, is hard to compete with. For example, if we bring in a board-certified physician just coming out of his training, we can only bring him in at $70,000. In my opinion, if this physician would go out in private practice, the first year he would be making at least $100,000. With experience and many years of practice, his income grows higher. There is an average income of the family practitioner probably from $125,000 up to $250,000 for the BC surgeon. So you can see that it's hard to compete.

Mr. STAGGERS. I realize that. My question is, Is there a group of students that we maybe should be encouraging, or is there a way that we can encourage certain groups of students or certain medical schools, or through scholarships or loans; what is the solution that you would see? We will never be able to compete salarywise. Is there a way to compete with loans or scholarships?

Dr. DE LAPENA. It is possible, in my opinion, that maybe we can give them a grant, like how the service has been doing for the physicians, where they are supported during their medical school and then promise to give so much post-graduate of their service to the VA. That might be an attraction.

Mr. STAGGERS. Is there a group of students that might be encouraged to do this, I guess would be the other question also? I assume that we're doing that to some extent.

Dr. DE LAPENA. There might be those students, yes. There is a difficulty in acquiring loans at this time, also, and that might be a possible solution.

Mr. STAGGERS. What about with the nursing? Are we having problems recruiting and retaining the nurses in this facility?

Dr. DE LAPENA. Not in our facility, no.

Mr. STAGGERS. Is there a reason for that, why we can't attract doctors but why we can attract the nurses? Is it purely monetary?

Dr. DE LAPENA. It is monetary essentially, yes.

Mr. STAGGERS. Is there an inconsistency with the pay raises? I understand there has been recent regulations which are helping promote the nurses who have been in the system. Has there been any inconsistencies within this facility for granting pay increases?

Dr. DE LAPENA. To nurses, no.

Mr. STAGGERS. What has been the experience with the new regulations as far as nurses are concerned? Have they been promoted and received salary increases?

Dr. DE LAPENA. Yes.

Mr. STAGGERS. That's all I have, Mr. Chairman.

Mr. EDGAR. Thank you very much.

Mr. Coley, did your engineering department do anything special because three Congressmen were coming today?

Mr. COLEY. We especially prepared the elevators, I understand, from the trip that you all took. [Laughter.]

We do have a project awarded to change our elevators, including the controls, completely.

Mr. EDGAR. I just wondered whether there was any special orders for paint up, fix up, because of the congressional delegation.

Mr. COLEY. No, sir.

Mr. EDGAR. We have been visiting lots of hospitals, and at one hospital we had to get out of a van at one setting and walk about 20 feet from the curbside to the entrance. They completely changed the sod, put in three or four plants, the day before we arrived. I am convinced that if we were to notify all 172 hospitals that the committee was going to visit 1 month from today, and then canceled the visit on the day of the visit, that we would make hundreds of modernization, paint up, fix up, improvements in the VA system. We may try that some time, just to see what would happen.

Mr. COLEY. Every little bit helps.

Mr. EDGAR. I know my colleague wants to get into this question, but let me preempt him with a question.

I noticed, Mr. Lawrence, from the statement of the Director, that some jobs money was made available to this facility. My two colleagues to my left, who are sometimes to my right, and I worked very hard together on something called the Edgar amendment to the jobs bill. The Edgar amendment to the jobs bill said that in areas of high unemployment 75 percent of those funds ought to be expended, and 25 percent of those funds ought to be expended in other parts of the country where there is low unemployment.

So we fought very hard and we were successful in both the House and Senate in making sure that the VA received some jobs bill funds. We persuaded the VA to expend those funds as aggressively as possible.

I had been briefed before I came here on the high level of unemployment, and then I note that over $200,000 of VA small construction fund money was sent back, sent back to a pool of funds, probably to be used to create jobs in other places and other parts of the country. But could you clarify for us exactly why this facility, in this area of high unemployment, could not have obligated that $200,000 worth of funding in some small projects in and around this particular facility, and why it was necessary to return those funds?

Mr. LAWRENCE. Yes, sir. I will ask Mr. Kirkpatrick and Mr. Coley to help me with this. But we completed here at Clarksburg twice the dollar amount of any other facility in West Virginia in our jobs bill projects. There was money that was turned back in. Under the terms of the program, we understood they could not be obligated and that they were to go to other places where there might be overruns on projects.

Probably due to the high unemployment rate in this area, we were able to get the contracts at much less than what was estimated for them.

Mr. EDGAR. Are you suggesting that you weren't permitted to reprogram those funds to other construction projects?

Mr. LAWRENCE. Yes, sir, under the terms of the project program.

Mr. EDGAR. Was that the regional office or central office? How was that decided?

Mr. LAWRENCE. I think it was mainly the time constraint, that because of this the central office was looking to put the funds where they could be obligated immediately within the timeframe.

Let me ask Mr. Coley to explain that further, sir.

Mr. COLEY. When the jobs bill first started we got a TWX telling us what projects would be considered. They gave us three guidelines. First of all, that the projects must be needed for maintenance repair work, these projects must be on your NRM program status, in the pending status, which is the listing that we maintain of all unfunded projects; that the projects should be labor-intensive was a primary consideration; projects should be ones which can be obligated within 90 days, and construction should begin as soon as possible. Those were the key elements deciding what projects could be funded through the jobs bill.

The supply service has mandatory regulations that require a certain amount of advertising, in certain time periods. Of course, there is design time that is required. So this all had an impact on what we could even identify for what we could use under the jobs bill.

I think I noted in my speech that we funded every project we had on our listing. We did get it out and we did get it obligated. Now, some of them came in lower than anticipated, one reason being the inflation factors added for future year funding. Because some of them were funded a year earlier than what we had planned on them being funded. Therefore, that would reflect in a lower price.

Plus we did go out into a favorable contracting climate as reflected in some of our bids. I think that is the primary reason we had the money left.

As far as reprogramming we did have restrictions; on the other hand, if you wanted it to go into one area specifically, the only way I know to do that under current regulations is to use what we call P&H, purchase and hire, where we design the project, we hire the people locally, and we watch over the project. The only problem with that was, the way the bill was written, the money had to be obligated by the end of the fiscal year. So if we had started a project and could not finish it by September 30, we would lose the money. So that ruled that out. So that is another one of the main reasons.

Mr. EDGAR. I want it to be clear I am not being critical of what you did, because I am pleased that you finished all of your projects. It just is a little disturbing because we get critics who take a look and say it wasn't needed or that there wasn't high enough unemployment in that particular area. There were regulations. A couple of those regulations, by the way, are not part of the law itself. They were regulations that were put on by administrative offices, either in the VA or as part of the administration of the program. I guess I'm a little disturbed that you weren't able to be a little more flexible in the way in which those funds were utilized, because it is clear to me that some of those funds could have been used in this area.

Mr. COLEY. We were asked why they weren't used in this area, and as Bill can probably tell you better than I can—he knows the regulations and the contract requirements—our hands were tied in certain areas.

Mr. MOLLOHAN. Will the gentleman yield?

Mr. EDGAR. I yield to the gentleman.

Mr. MOLLOHAN. Thank you, Mr. Chairman.

Of course, we have discussed a number of times with the staff this jobs bill situation. The chairman took a real leadership role on, as he said, the Edgar amendment, which was the targeting amendment that channeled those funds into high unemployment areas, which, unfortunately we were one. So it was very disconcerting to learn, No. 1, that the funds weren't all spent, and No. 2, that a number of contracts were let to people outside of this area. I have requested, and shortly should be receiving, a complete report on that from the VA.

I do understand, while I had concerns with the local operation of it, that a lot of the direction for spending of the jobs bill money came from the national office. I appreciate that.

Let me followup on one thing you said that I want to make sure I understand. Is it your understanding now that the jobs bill money not only had to be committed but had to be spent before the end of the fiscal year, 1984?

Mr. COLEY. It had to be obligated.

Mr. MOLLOHAN. It did not have to be spent, though?

Mr. COLEY. Unless you were under P&H. If you were under purchase and hire, it did have to be spent.

Mr. MOLLOHAN. OK. So under purchase and hire you said it had to be spent; otherwise, it just had to be obligated.

Mr. COLEY. Yes, sir.

Mr. MOLLOHAN. I wanted to make sure we understood that.

Mr. Chairman, thank you for bringing that up.

Mr. EDGAR. I am sorry to take that issue from you, but——

Mr. MOLLOHAN. No, no. You did an excellent job with it. It is probably better for you to have done it than me anyway.

Mr. EDGAR. Let me ask a couple of other questions, and I know my colleagues have additional questions. I want to ask all our additional witnesses for their patience. The additional panels will not take quite as long. We want to make sure we have asked all the tough questions.

When do you think this facility will get a nuclear magnetic resonance machine?

Dr. DE LAPENA. It's a dream. I don't think we ever will get it.

Mr. LAWRENCE. Mr. Kirkpatrick, is that on our equipment needs list at present?

Mr. KIRKPATRICK. I'm afraid not.

Mr. EDGAR. I raised the question, and I knew the answer to it. I also know this facility does not have a CAT scanner. It occurs to me that is part of the future but also a part of the problem we face in trying to keep the veterans' health care system on the cutting edge of the future in terms of the delivery of health care. I am convinced that there are some new technologies that are noninvasive, surgical procedures and noninvasive diagnostic procedures, like NMR's and other machines that will be part of the wave of future health care, where you will be able to take a picture on Monday, give a treatment on Tuesday, take another picture on Wednesday to see if your treatment worked. According to some of the early estimates, more than half of the exploratory surgery that presently takes place, to open someone up and go in and look for something, can be avoided if you, in fact, know what to expect and what's inside the body, either in the brain or in some other part of the body. I think we're really going to have to look at a way to accelerate the time from the experimental steps of this new technology to the point where you can use it.

We talked earlier in our tour about the fact that it costs you $280 or $300 to buy a CAT scan someplace in the neighborhood—or referral to another hospital—is that correct?

Mr. LAWRENCE. Yes, sir.

Mr. EDGAR. My guess is that some medical people tend to think twice before they order a CAT scan because it means taking the patient literally outside of the hospital. My father died a few years ago at age 56, a brain tumor, and he sat for about a day-and-a-half on a little cart in the hospital about 30 miles away from the neighborhood hospital, simply because the neighborhood hospital didn't have access to that CAT scanner. I became very keenly aware of the trauma that patients go through in order to get that kind of diagnostic help. So I think all of us have to be eager to say how do we get to the future as quickly as possible.

A lot of it is money, and the VA and OMB have to understand that. A lot of it is figuring out how to plan well so that the facilities, when they do enhance some part of the health care system, do it well.

Let me ask you a final question and then I will yield back to my colleagues.

If you were to select the three things within this facility that you are most proud of, what would they be? Then, quickly, what would

be the three things that you are most dissatisfied with within this facility. Let me ask the Assistant Director to respond to that question.

Mr. LAWRENCE. Would you like a consensus of opinion, or my——

Mr. EDGAR. Just basically your opinion would be fine. If we were to get a consensus in this room, it would take us most of next week.

Mr. LAWRENCE. Touché.

I personally am proud of the dedication that I observe among the employees of this facility. Without that dedication, I don't think, with the resources of a small facility, that we could accomplish what we do. This is reflected in the comments from patients, relatives, and the public in general.

I am proud also of the enthusiastic manner in which our people do look to the future and want to embrace new programs. That is a very prevalent attitude here. It is not a status quo situation. It is rather a situation where we are looking to the future and trying to embrace the programs that we know the patients of this area need.

The third thing that I would be proud of is the fact that we are part of a system such as the Veterans' Administration that we can be proud to relate to because the veterans that we treat represent 40 percent of the population in any area and we are dealing with something that gives us personal satisfaction.

The three things we are the least proud of, one, of course, is the glaring space deficiency at present. It just doesn't give us the facility to do what we need to do. We do get by with the dedication of the staff and some of the other things I mentioned. Hopefully, this will soon be corrected with the clinical addition. At that point we will have additional problems, however, and I think we will be able to address those at that time and plan for the future again continuously.

I would like to say that—you haven't told me so, but I would say that before the day is over you will tell me this is one of the cleaner facilities, even though it is 30-some years old, that it is fairly well kept. I should have added that as the fourth something that we're proud of. I think that our staff is required to go beyond the call of duty in many cases and that would be a second thing I'm not proud of, that we can't support that staff with the additional workers that we would like to. But that, we hope, will be overcome soon.

Before I hog everything, let me see if there are other areas.

Mr. BANASSO. Additional money.

Mr. LAWRENCE. Additional money. As I believe you mentioned, Chairman Edgar, money would solve a lot of problems.

Mr. EDGAR. "The check is in the mail."

Mr. LAWRENCE. Thank you, sir. We appreciate it.

[Laughter.]

Mr. EDGAR. I yield to my colleague, Mr. Mollohan.

Mr. MOLLOHAN. Mr. Chairman, following up on your questions about equipment and wish lists, I note in Mr. Kirkpatrick's testimony he raises real concerns about additional equipment funding and goes through the various amounts that have been allocated for each of the fiscal years. We are in a decreasing mode, aren't we, if I look at these figures and understand them correctly.

Why don't you talk to us about that a little bit.

Mr. EDGAR. Before you do, if the gentleman would yield, a lot of other funds that come to the VA hospitals to the directors are earmarked funds. Isn't the equipment fund one you can snitch from?

Mr. KIRKPATRICK. No, sir.

Mr. EDGAR. Is it earmarked only for equipment?

Mr. KIRKPATRICK. It is earmarked for equipment and you cannot commingle, with other funds even between the two categories of replacement and additional equipment.

Mr. EDGAR. So you don't downplay the equipment fund for, let's say, pharmacy or some other thing that has skyrocketed?

Mr. KIRKPATRICK. Definitely not. All money that we receive for equipment is spent for equipment.

To get on a little bit with your request for comments, the situation exists whereby with the amount of replacement funding we're getting on an annual basis, it never meets the needs of that particular year. Therefore, all you can do at the end of each year is to re-evaluate equipment needs you were unable to meet and decide whether or not they can be pushed forward into the next fiscal year. Hopefully engineering service will be able to keep it in some sort of state of repair that will enable us to continue to use it. At any rate, we're into a ballooning effect with the replacement equipment. Each year this happens.

Just from memory, I project it will be necessary to move $300,000 of replacement equipment needs for this year into fiscal year 1985. Fiscal year 1985 equipment needs are already projected at around $400,000 or $500,000. If this continues on we'll never be able to take care of the problems.

Mr. MOLLOHAN. So the problem is accumulating; that's what you're saying.

Mr. KIRKPATRICK. Yes.

Mr. MOLLOHAN. Will the advent of the clinical addition help out? Do you expect, along with its completion, to get an equipment account to——

Mr. KIRKPATRICK. We will identify replacement and additional equipment needs in that project. However, all of our needs do not associate themselves with the clinical addition project. Therefore they cannot be included with that project.

Mr. MOLLOHAN. Would the ability to commingle the funds between new and repair, however you described it, would that provide any significant relief?

Mr. KIRKPATRICK. It would permit the medical center director to manage the money more efficiently than he now has the opportunity to do.

Mr. MOLLOHAN. To be able to make that choice between priorities.

Mr. KIRKPATRICK. That's right.

Mr. MOLLOHAN. Is that a statutory restriction or is it just simply VA policy, a regulatory restriction?

Mr. KIRKPATRICK. If you would permit me, I would ask our chief of fiscal service, who is here, to respond to that question.

Mr. EDGAR. Speak into the microphone and identify yourself, please.

Mr. PISEGNA. Yes, sir, Mr. Chairman. I am Robert Pisegna, Chief of Finance Service.

The way it is right now, it is a VA requirement that you cannot intermix the additional and replacement moneys. The way I understand it, it came down from OMB that they want to track the allocations. In other words, they want to keep the allocations pure.

Mr. MOLLOHAN. So it is an OMB restriction, essentially?

Mr. PISEGNA. Yes, that's the way I understand it. OMB directed the Veterans' Administration, along with other agencies, to do that.

Mr. MOLLOHAN. OK. Thank you.

We are very limited on time and the chairman has graciously given me permission to pursue one more line of questioning, and information we received at the Martinsburg hearing makes it of even greater interest to me. In Martinsburg we asked some questions about the ability of providing medication for nonservice-connected veterans. They have a very high percentage of their caseload that is nonservice connected and they do supply that medication.

Would you describe for me to what extent you do provide medication for nonservice connected, what your rules are for providing that service?

Mr. LAWRENCE. I will let Mr. Alvaro talk about this. We do provide, we believe, all that the veteran is entitled to. In other words, we are not shortchanging a veteran to his entitlement. There may be some problem with the entitlement there, though.

Mr. ALVARO. We provide nonservice-connected medications for veterans who have been hospitalized for a period and discharged to the clinic, what we call the outpatient treatment clinic. He is carried on that clinic's rolls until such time the physician feels he can be discharged from those rolls. We have an average time on the outpatient, nonservice-connected rolls of 10 months. We have 2,000 presently on the outpatient rolls, nonservice connected. That is one category.

The other category is those seeking care for chronic conditions which does not warrant hospitalization. We are given regulations to treat these patients on a one-time basis. When we see them today, we can return them for one more time to obviate the need of hospitalization. If they have chronic conditions, we can no longer treat those chronic conditions to exceed that period. Therefore, we reject a large population of our veterans who are nonservice connected that do not need hospitalization but do need medication.

Mr. MOLLOHAN. What percentage of your patient load is nonservice-connected inpatient?

Mr. ALVARO. Outpatient, I would say we have a mix of 46 percent service connected, 54 percent, non-service connected.

Mr. MOLLOHAN. Wait a minute, wait a minute. Tell me again. This is nonservice connected.

Mr. ALVARO. The inpatient mix is approximately 60 percent nonservice connected and 40 percent service connected.

Mr. EDGAR. Would the gentleman yield?

Could you provide the exact figures for the record over the next week or so?

Mr. ALVARO. Sure.

Mr. EDGAR. And could you send those to the committee?

Mr. ALVARO. I can give them to you, if I would be able to go through these stats, I could probably give it to you in a——

Mr. EDGAR. It would be helpful if we could be real accurate in terms of the exact percentage for fiscal year 1983 and the projection for this year of service connected versus nonservice connected, in both inpatient and outpatient.

Mr. ALVARO. All right.

Mr. MOLLOHAN. If you could supply it for the record, it would be easier on you.

[Subsequently, the Veterans' Administration furnished the following information:]

Following is a comparison of service-connected vs. nonservice-connected veterans treated at VA Medical Center, Clarksburg, West Virginia.

[In percent]

	Inpatient		Outpatient	
	Service connected	Nonservice connected	Service connected	Nonservice connected
Fiscal year 1983	22.8	77.2	46.5	53.5
Fiscal year 1984 (projected)	28.4	71.6	46.4	53.6

Mr. ALVARO. I want to make a point. Like I said, the increase—it's in my statement. The increase; we are looking at an 84-percent increase impact on us at this time. Eighty-two percent of those patients, like we said before, one first-time admission, veterans we see for the first time, for the most part they will be with us probably as long as the economic conditions are what they are around here. We have to turn those veterans away. They're between 45 and 62 years old, without funds, with no employment, a lot of pride, and they have asked us for the first time to serve them. They come here and we deny them on the basis that we're mandated by the nonservice-connected law, which I feel is unfair, in my opinion. But we refer them over to the social work people. We ask them if they would stay and see the social worker, and contact somebody in their community who would give them some type of help or medication. For the most part, you can verify it with the social work people. These people have a lot of pride and they just walk off.

We have probably generated a lot of mail to our Congressmen. We see maybe one or two letters a day. They're upset that they have been denied services and they aren't going to see any social work services in the community.

Mr. MOLLOHAN. Just so the committee and I can understand, you are able, under the law and under regulations, to provide medication to nonservice-connected veterans; just answer that.

Mr. ALVARO. Yes.

Mr. MOLLOHAN. That's yes. But there are some limitations on that.

Mr. ALVARO. Eligibility criteria.

Mr. MOLLOHAN. Now, it is not eligibility, is it? Isn't it finances. In other words, you are able to provide that medication up to the limit of financing. Is that the criteria?

Mr. ALVARO. No, that is hospitalization.

Are we just talking about medication?

Mr. MOLLOHAN. Yes.

Mr. ALVARO. They are not asked about how much money—when he makes application for hospital treatment, he makes application for outpatient, inpatient, whatever his needs are. The only limitation there, he is asked if he is nonservice connected; if he can afford hospitalization. If he says yes, he can defer the cost of hospitalization, then he's not entitled. We never have many problems with that because, for the most part, when they come here, none of them are working or have any third party carrier. But if he is service connected, whether 0 percent or 100 percent, he can ask for medications for his service-connected condition and be given it.

Mr. MOLLOHAN. Thank you, Mr. Chairman.

Mr. EDGAR. Thank you.

Mr. Staggers.

Mr. STAGGERS. Thank you, Mr. Chairman. I will try to be brief in the interest of time. I just have one area I would like to dwell on, and there may be one or two questions.

I hate to keep picking on Mr. Alvaro, but the question is basically directed toward you. The area that you serve is very large, and within your statement, on page 4, your first comment deals with the agent orange problem. It would appear from the alternatives that you have set out, that to eliminate the problem you're either going to have to curtail the workload or add an additional physician in the outpatient area. That boils down to you're either going to have to spend more money or cut services. The trend has been to cut services.

Is that what we can expect?

Mr. ALVARO. Up to this point the management has agreed to give services to everyone as much as possible as the budget would allow us. We are stretching right now with every possible resource we can to give some of those deserving veterans that medication, if at all possible, without turning them away from the hospital. But we will have to do one or the other.

We were seeing one veteran a day claiming disability related to agent orange. We are now seeing three to five a day. We are using up 5 hours of the hospital's time, both physicians and the clinical delivery services. We are waiting until 6 to 6:30 in the outpatient area. Our doctors are holding up without asking for any benefit at all or overtime. For the most part, two of our doctors in the outpatient area remain here most every evening until after 5 o'clock to make sure we get through all the veterans who have patiently waited until we get through with some of these extensive examinations.

Mr. STAGGERS. As part of the outpatient care that you provide, do you provide counseling, also, such as Vietnam readjustment counseling clinics? Do you get involved in that at all?

Mr. ALVARO. The hospital is involved with that. We have the outreach in Morgantown. It is budgeted. The control point money is here with the director at this hospital, so we are involved.

Mr. STAGGERS. Are you educating the veterans who are eligible that there is a facility in Morgantown?

Mr. ALVARO. We also have the director of that program probably here in the audience. I saw him. It is Mr. Bechtel who directs that program. He is here I think once or twice a week with sessions. He has them there in Morgantown, in this area, plus in this hospital.

Mr. STAGGERS. He does a very good job, too. I am concerned about this large area and just having the two facilities within West Virginia, and are we serving the rural veterans. I have addressed this problem with him.

Mr. ALVARO. I am not sure how many he is getting to, but I do know he is dedicated and he works hard. He is here probably twice, maybe three times a week. I know he's only supposed to give us probably one day, but he is giving us maybe two or three.

Mr. STAGGERS. That's all the questions I have.

Mr. EDGAR. The only reason we didn't put a water pitcher at the table there is because we knew we were going to keep you as long as we did and we didn't want you to have to leave us.

I want to commend each of you for taking the time—that was a joke. [Laughter.]

I want to commend each of you for taking the time, particularly Mr. Lawrence pinch-hitting for the director, with our questions and grilling. I know that Mr. Mollohan has about 6 more hours of questions and Mr. Staggers has at least 3 more hours of questions, and I haven't even looked at the questions that the staff has prepared. But we're not going to get into those.

You have been really kind to us, in helping us to understand how the system works from the grass roots perspective. The veterans organizations which are here and the other witnesses who will testify may comment pro or con on some of the things you have said. I hope some of you will stay and listen to their comments because we find that very productive. But let me thank you for taking the time to prepare your statements, for sharing them, and for being available to us for additional questions. We may have additional questions for the record which we will submit to you. Thank you very much for your time today.

Mr. LAWRENCE. We thank you very much, Mr. Chairman, for being here at our facility today. We invite you to come back as often as you can, sir.,

Mr. MOLLOHAN. Please extend our condolences to the Director.

Mr. LAWRENCE. I will do that, sir.

Mr. EDGAR. Our next witness will be Mr. Richard Conrad, service officer, West Virginia Department of Veterans Affairs. Mr. Conrad, we appreciate your patience this afternoon. I do hope that you will be able to abbreviate your statement for the record and not cover ground that has already been covered. We appreciate your coming today.

You may proceed.

STATEMENT OF A PANEL CONSISTING OF RICHARD CONRAD, SERVICE OFFICER, WEST VIRGINIA DEPARTMENT OF VETERANS' AFFAIRS; PAUL HASTINGS, PAST COMMANDER, DEPARTMENT OF WEST VIRGINIA, MILITARY ORDER OF THE PURPLE HEART; CLARIS TALKINGTON, ADJUTANT, DEPARTMENT OF WEST VIRGINIA, MILITARY ORDER OF THE PURPLE HEART; MARBLE ZICKEFOOSE, THE AMERICAN LEGION, CHAIRMAN, VOCATIONAL REHABILITATION, THIRD DISTRICT, DEPARTMENT OF WEST VIRGINIA; WILLIAM GOLDEN, STATE HOSPITAL CHAIRMAN, VETERANS OF FOREIGN WARS OF THE UNITED STATES; JOHN NICHOLSON, DEPARTMENT OF WEST VIRGINIA, VETERANS OF FOREIGN WARS

STATEMENT OF RICHARD CONRAD

Mr. CONRAD. Thank you.

Your committee has already been given a copy of the testimony that the Department of Veterans' Affairs of West Virginia wishes to present.

Mr. EDGAR. Without objection, the full statement will be made a part of the record.

[The statement follows:]

PREPARED STATEMENT OF RICHARD CONRAD, SERVICE OFFICER, WEST VIRGINIA DEPARTMENT OF VETERANS' AFFAIRS

Mr. Chairman and Members of the Subcommittee on Hospitals and Health Care Committee on Veterans' Affairs: The West Virginia Department of Veterans' Affairs is pleased to have this opportunity to present it's views on the matters scheduled for your consideration today.

I would like to start my testimony by stating that Governor John D. Rockefeller and the West Virginia Department of Veterans' Affairs is very pleased with the progress that has been made by the Veterans' Administration in funding medical construction in our four West Virginia Medical Centers. Because of the increasing average age of our WWII veterans, nursing home care is a realistic need for our approximate 243,000 veterans in the immediate future and we applaud your actions in making this a reality.

We here in West Virginia propose in our long range plans (possibly within the next five years) to increase our level of care at our Barboursville Veterans Home Domiciliary to include nursing care.

We do have some concern in specific areas of medical care that I believe this subcommittee should be made aware in an effort to rectify and/or make recommendation for changes to such.

Area No. 1.—Six month delay in issuance of Champ-VA cards to dependents after initial application for such. (I believe applications should not take this long for issuance).

Area No. 2.—VA automatically cuts veterans off their medications if they have not used their outpatient card within two years. (I believe a letter should be sent to veterans permitting them ample time to provide evidence showing he is entitled due to service connection/housebound/aid and attendance/ WWI or etc.

Area No. 3.—Veterans who lose entitlement to outpatient treatment by their personal physician who do not use their outpatient card for two years should be notified prior to discontinuance of this benefit.

Finally, this department has 16 field offices throughout the State of West Virginia which refer those veterans in need of medical care to the four medical centers. I might add we have an outstanding working relationship with these medical centers and have the highest regard for the level of care they provide and are proud of the achievements they have made in updating their facilities with the most modernistic equipment in today's medical field.

Mr. CONRAD. The only thing I would have that is a concern of ours—well, there are two things. First is what we have discussed briefly the non-service-connected drugs. As you are aware perhaps,

many of these veterans have as their sole income the veterans pension, the non-service-connected pension, $459 a month. Many of them have been coming to this facility or to a VA facility for maybe 20 years. They have no private physician and have never bought drugs. When this is presented to them, it does put an extreme hardship on them. We feel it should be looked into. We know that at the present time, as has already been testified to, they are considered ineligible for medication under the policy of the VA hospitals and under the laws in which they operate. But we feel this should be given some consideration.

The second item deals with the aging veteran that was discussed previously. Our State veterans home at Barboursville currently is domiciliary, a capacity of 201. It is not full at the present time domiciliary.

As also in the testimony, within the next 5 years, which Mr. Alvaro probably wasn't aware of at the time, within the next 5 years we hope to increase this level of care to include a nursing home and will be looking for encouragement from the OMB for the State home.

Last, an item in our testimony that was not apparently a problem at the Martinsburg hospital that we feel may be a problem here, is the area of testimony which relates to the length of time it takes to get a CHAMPVA card for a dependent of a veteran.

Mr. EDGAR. Thank you very much.

Can I ask you who pays your salary?

Mr. CONRAD. The State.

Mr. EDGAR. So you are an employee of the State of West Virginia?

Mr. CONRAD. Yes, sir.

Mr. EDGAR. And your primary function as a service officer for the State of West Virginia is to do what?

Mr. CONRAD. To develop and process claims, to get the benefits for the veteran from the Veterans' Administration, and any other——

Mr. EDGAR. How many service offices are there?

Mr. CONRAD. Our department has 16 offices throughout the State of West Virginia in the major cities.

Mr. EDGAR. Do you have any direct services that the State of West Virginia provides?

Mr. CONRAD. Yes, sir. The State, in addition to those educational benefits that are paid to dependents, of veterans killed in service or dying from service connection, we have the War Orphans Program that pays tuition to the State-supported schools and monetary awards to students that go to schools that are not State supported.

Mr. EDGAR. Does your service department also control the State veterans home; are you responsible for that?

Mr. CONRAD. Yes, sir. It falls under the Director of State.

Mr. EDGAR. Do you have any plans for a second or third or fourth State veterans home that would alleviate some of the nursing home needs?

Mr. CONRAD. I would think not at the present time, since the Barboursville Veterans Home is relatively new—3 years old. We haven't reached capacity in it. There is a large turnover of veterans at the home.

We have been made more aware of the need for nursing home, the aged problem and nursing homes, since we started operating our veterans home. Due to the fact that many of the veterans come to us in domiciliary, in a couple of years we are no longer able to keep them as a resident of the home and they have to be discharged to some other place. There is no place for them.

Mr. EDGAR. Thank you. I appreciate your testimony today and would just hope that as you work with your State legislature and your Governor in trying to provide veterans health care that you will look at the ways in which the Federal and State Government can share that responsibility as we are doing in the State home that you do have.

Mr. CONRAD. Thank you, sir.

Mr. EDGAR. Mr. Mollohan.

Mr. MOLLOHAN. Mr. Chairman, I would just like to make an observation, that Dick shares something in common with the members of the other panel; that is, he is a really dedicated public servant on behalf of veterans, and I know because he deals with my office closely and is always working for the best interest of veterans. I appreciate very much having his contribution to these hearings.

Mr. EDGAR. Thank you very much.

Mr. Staggers.

Mr. STAGGERS. Thank you, Mr. Chairman. I want to compliment you on the 5-year plan for an additional nursing home. I have no questions but just a suggestion that maybe looking geographically at a second home, that may be a factor that you can get a full house.

Mr. CONRAD. Yes, sir. I think it is something to be taken into consideration, because I have observed there is not as many veterans seeking application or making application to the home in Barboursville from the northern part of the area as there is from the southern part.

Mr. MOLLOHAN. Will the gentleman yield?

Mr. STAGGERS. I will.

Mr. MOLLOHAN. I think that is a very important point that I would like to understand more fully and, of course, will pursue in other hearings. It is the geographical aspect of whether a nursing home is attractive to a veteran or not attractive. I think that is something that has to be looked at and it is an excellent point that you raise.

Mr. EDGAR. Thank you. I have no further questions. I appreciate your willingness. You are welcome to stay and listen to the rest of the panel and answer other questions that may come up.

Gentlemen, we appreciate your patience today. I am going to ask each of you to make your statement. If you have a prepared text, it will be made a part of the record; if not, I would ask that you just summarize your comments or highlight issues that you would like to raise with us.

We are going to start with Mr. Stump, who is adjutant, Department of West Virginia, Veterans of Foreign Wars. We will go down through Mr. Hastings, Mr. Talkington, who came in full military dress, or veterans dress. We appreciate your coming. We will hear

from a couple of other of you as well. I am not even going to begin to pronounce your name, Mr. Zickefoose.

Mr. ZICKEFOOSE. That's good.

Mr. EDGAR. That's a famous name that Pennsylvanians can't pronounce. I apologize.

Mr. ZICKEFOOSE. It means goat's foot in German.

Mr. EDGAR. OK, Mr. Goatsfoot. And Mr. Bill Golden will be last. Let's hear first from Mr. Stump.

STATEMENT OF RALPH STUMP, STATE ADJUTANT, QUARTERMASTER, WEST VIRGINIA DEPARTMENT, VETERANS OF FOREIGN WARS

Mr. STUMP. Thank you, Mr. Chairman. My name is Ralph Stump, the State adjutant, quartermaster, Veterans of Foreign Wars. I am here today representing our organization. I believe you met our State commander at the Martinsburg hospital this morning and I was asked to come here and represent our organization. I think with our two great colleagues from West Virginia who have worked with you, we are as proud of them as you are serving on the committee. I think you are well aware of the Veterans of Foreign Wars stand on the VA hospital system and the VA system as a whole.

Mr. Conrad, of course, is the expert here today who will be testifying if any questions need answering, and if you have any questions concerning the Veterans of Foreign Wars positior., I will be happy to answer them.

Thank you.

Mr. EDGAR. Thank you, Mr. Stump.

Let me just say something. You mentioned my two colleagues, and I am very proud of them. They will have distinguished themselves on this committee when they're as old as I am, with all the wrinkes that I have and grey hair. But let me say, in the year and a half that they have been on the committee, they have not only distinguished themselves but they have been two of the most vocal members of the committee on behalf of West Virginia's needs. I think that is important to you as a State and as veterans organizations, because so often the voice of a State like this, that is hidden away, and has enormous unemployment problems, does not get heard as loudly in Washington and gets overwhelmed by Texas and California and New York, particularly Florida, which keeps reminding us of how many new veterans are moving into the State of Florida. It is important for those who do have concerns to be well represented, and you are very well represented on our committee.

Mr. STUMP. Sir, might I add that they have had not only some training from you but, having worked with their fathers for a number of years on veterans' affairs, they have had some good training.

Mr. EDGAR. Their fathers have been on my case for years, too.

Mr. MOLLOHAN. Things come full circle.

Mr. EDGAR. That's right.

Mr. Hastings, we really appreciate your being here today.

STATEMENT OF PAUL HASTINGS, PAST COMMANDER, DEPARTMENT OF WEST VIRGINIA, MILITARY ORDER OF THE PURPLE HEART

Mr. HASTINGS. Thank you, Mr. Chairman, Congressmen. I do not have any prepared text today. Let me thank you for coming to the great State of West Virginia, particularly to the Clarksburg Veterans Hospital.

What you have heard from our staff today here I think was very, very comprehensive. They are very dedicated people, which was very obvious. I come here a lot, not only as a patient but as an observer, visitor, whatever you might call it, and they are very, very dedicated people.

Mr. Chairman, in defense of the housekeeping man, the engineer, no, they didn't do any particular cleaning up. They might do as you or I, where they might spruce up a bit when they know they're being visited by VIP people. But they didn't do any particular cleaning up because it is always clean. This is a very clean hospital.

Now, getting back to the nonservice connected, I might say, being from the Purple Heart, that we are not only geared to try to service as much as possible the service connected, but also the nonservice connected. I recognize the law that we have on the books, but West Virginia is a small mountain State and up here in these hills we don't have people that always worked on heavy industry, where they may have been getting a pension, so they are on a low-fixed income. They need this medical attention. They need the medicine that they can get from this hospital. So if we could possibly change or possibly bend the rules, that would be fine.

Once again, I recognize the laws are as such. But it is a problem. As I say, we are not only for service connected, service combat wounded, but we also recognize the nonservice connected and the noncombat man as much as we recognize the combatant in a military operation. Mr. Congressman, it takes all of us to be in a war, and that is for sure. So I would give the mike down here to someone else and be subject to any questions you might want to ask.

Mr. EDGAR. Thank you. I would like to commend you on your statement, and also say you did add an additional piece. We were talking earlier about long-term unemployment, those who fall off the unemployment rolls and those who fall outside their health care packages, but you reminded us that this State has a number of retired persons who didn't work in industries that had retirement pensions and, in fact, may have retired with only their social security or only their veterans' pensions, and those persons may have a more specialized need to see this health care system as their only health delivery system. I appreciate you raising that point which was not as clearly raised earlier.

As to your point about fixing up and the engineer, he can take care of himself in terms of defense. We do sneak back every once in a while in disguise and we'll check out the cleanliness of the system some Friday afternoon at 4 o'clock.

Thank you for your comments.

Mr. Talkington, let me ask you to take the microphone. We welcome you here. It is good to have a consumer with us.

Mr. MOLLOHAN. Will the chairman yield for just a second before Mr. Talkington speaks?

Mr. EDGAR. I yield.

Mr. MOLLOHAN. I want to say that I probably have the explanation for why he is now a patient in the hospital. Last month "Talkie" organized in a very outstanding way a number of veterans' meetings. I think he has probably worked himself into exhaustion. I know he had me driving all over the First Congressional District in West Virginia and I was exhausted trying to keep up with him. But obviously, his being here today, indicates that if he has been ill, he is well on the way to recovery. I am glad to see him here.

Mr. TALKINGTON. It is a pleasure to be here, Congressman Mollohan. You will never know how much it meant to me, having you follow me around on these rounds in our great State. I really enjoyed having you at all these meetings we had with the veterans. I am sure you heard a lot of things that they had to say in regards to our State, and therefore I know that you are aiming to help us the best you can.

I would like to say to you that I don't have much more to add to what Paul has said, but it is a pleasure to be here with you fellows today and to see you all again.

Mr. EDGAR. How long have you been in the hospital?

Mr. TALKINGTON. About 2 weeks, sir.

Mr. EDGAR. I hope things are going well for you.

Mr. TALKINGTON. Yes, sir.

Mr. EDGAR. How's the quality of care?

Mr. TALKINGTON. It's good, sir, so far. It's fine.

Mr. EDGAR. If you have any complaints, talk to Mr. Mollohan.

Mr. TALKINGTON. I will. [Laughter.]

Mr. EDGAR. No, I'm just teasing.

Mr. TALKINGTON. If I have any complaints, I'll chase the nurses. [Laughter.]

Mr. EDGAR. Mr. Zickefoose.

STATEMENT OF MARBLE ZICKEFOOSE, CHAIRMAN, THIRD DISTRICT, DEPARTMENT OF WEST VIRGINIA, THE AMERICAN LEGION

Mr. ZICKEFOOSE. Mr. Chairman, members of the committee, I want to welcome you to this part of our great State. I have no prepared statement but I do have a few notes here that I would like to bring to your attention.

I am a member of the American Legion State Commander's Committee to this hospital and to the Weston hospital. Also, I am service officer for Post No. 7, the American Legion, in Buckhannon, and work very closely with these people in this VA center.

I have observed the expanded influx in the outpatient and inpatient load, utilizing the beds to approximately 96 percent of their capacity. This influx, no doubt, has caused a very definite strain not only on personnel but on their budget.

We are pleased at the added therapies here in radiology and chemotherapy which preclude the transfer of people to other hospitals throughout the VA system. Particularly in a rural area like

my county, the veterans appreciate the fact that they can come here and receive a service without being transferred all over the State or out of the State. I realize there are some treatments that do have to go out of the State. I personally have an appointment being made now that I think I'm going to have to go out of State, but those are necessary and there is no objection. When we do go, my people have reported good service. There is no complaint that I have ever heard of the service rendered in this hospital. The orthopedic and urology services are rendered here now and we are appreciative of that.

Now, all of this, as we see it, leads to a well-rounded medical service program, not only for veterans, but needed to retain the interest of the West Virginia University Medical School in cooperating and supporting this VA center and the three colleges that furnish nursing students to be trained, and get experience in this hospital.

We are sure that the workload here, which is barely being met now, with the continued influx will certainly overtax the current staffing and the budget.

I have noticed in my visitations here, and also as a patient, that the outpatient area is overloaded all day long. The only complaint I have really ever heard from our people is that they have to wait so long after they get here to receive some kind of medical consultation. That is the holding part of the outpatient area, and that is understood certainly, but it is still a thorn in the side of the people that have to come here and lounge around all day.

My experience with the efficiency here has been as a patient and in talking to other people, veterans that have been patients here, both in- and outpatients. The cooperation of the management has been outstanding. Mr. Alvaro has been real considerate and concerned about special cases that I have brought to him. One of them was a transfer of a man from the Weston State Hospital to the Chillicothe Hospital, and this is not always the easiest thing to do. But we received excellent cooperation there and it was taken care of promptly.

I was a coordinator in the State health department for about 3 years, in an emergency medical services program that we initiated in the State, conducting a training school for the ambulance drivers which at that time primarily came from funeral homes and hadn't received a lot of training in emergency care. It was my job to coordinate the program. First, we made a survey of the system and then went into a training program. We conducted a course throughout the State at 11 different points and recruited the ambulance drivers into the course. We brought physicians from the university medical school in to train these people, to give them instruction in an 8-hour concentrated course. From there, we conducted an exercise using the providers to demonstrate the efficiency or inefficiency of the system, using moulaged cases, and bringing them by ambulance into the hospitals.

I am bringing this up for the simple reason that we appreciated at the time the cooperation and the support of the veterans' hospitals in the State, and this one in particular. This is as it should be. Because in any disaster, and having served 4 years as assistant civil defense director in the State, I am aware of what we need

sometimes in disasters. The veterans' hospitals can serve as focal points and providing leaders in organizing and training in disaster programs. I think some consideration should be given financially to planning and executing disaster programs, whether it be floods, tornadoes, cyclones, nuclear, or other.

Mr. EDGAR. I hope you don't say nuclear too quickly. That's a little different than a cyclone.

Mr. ZICKEFOOSE. Yes; I am very much aware of that because I have worked some in the training along that line, radiation and monitoring. I am really not worried too much about it, especially with the proposed defensive sytem that we hope to put into space to counteract the Russian missiles coming over. I am sure the chairman has heard about that, as well as the whole committee. I have been following that possibility rather closely, and am very much interested, especially being a retired Army officer.

Thank you very much for coming to our area.

Mr. EDGAR. We appreciate your statement and appreciate the thoroughness of your comments.

Mr. Golden.

STATEMENT OF WILLIAM GOLDEN, NATIONAL SERVICE OFFICER, DEPARTMENT OF WEST VIRGINIA, THE AMERICAN LEGION

Mr. GOLDEN. Mr. Edgar, Mr. Mollohan, and Mr. Staggers, it is a pleasure to listen to you people on the panel today. All I have to say is that I am hospital chairman for the State of West Virginia, for the volunteers, the VAVS. That's my job here.

In my visiting and running around, I haven't had many complaints. I have had maybe two of them. I have gotten complete cooperation out of the staff at the hospital, and I know they are being taxed because I have seen them send people that maybe live 50 miles from here that should have been in the hospital, they didn't have room for them and had to send them back home. I have helped them back into their vehicles to get back home. I could even give names if I had to.

In the waiting rooms, this is another complaint. They have to wait too long to be taken care of. There is no choice. Outside of the shortages in these two things, they're doing a remarkable job.

I have never been in this hospital as a patient myself, but I have had three brothers here over the past 15 years. They tried to get attention in the other hospitals and didn't get the attention they needed. They had to release themselves and come to this hospital to get the attention they wanted. If I had anything seriously wrong with me, I would like to come here myself; but the way they've got things set up now—like I wrote to Mr. Mollohan recently about this. I'm getting up in that age that they're talking about. I'll be 65 pretty soon, with medicare.

Well, the group that I am with is what they call the notch years. I wrote to him about this. And the same thing with this hospital. When I retired in 1980, everything that I was involved with, the Reaganomics and this sort of thing has hit the hospital, has hit me. I would rather have my career right here. I have had insurance with an outfit—and this is another thing they have never taken

into consideration or talked about. The insurance that I carry, they won't pay to a Government hospital. Why doesn't the State insurance commission or the Government itself take this insurance? I don't care who gets the insurance. I would rather have my attention right here. I'm a veteran. This is all I have ever gotten out of the service for the time I put in, and this is all the veterans are asking. The only thing I am interested in, in the work that I'm doing here, is the welfare of the patients, the welfare of the veterans. They are getting good care here. But there are some of them being passed by because of some of these regulations.

For instance, the outpatient care. Maybe some of them can afford to handle it, but there's a devil of a lot of them that can't afford it and are being turned out on this non-service connected deal. This, as a whole, is what I have to say.

Before I quit, I want to thank Mr. Mollohan for taking care of some past work for me here a couple of years ago, for at least looking into that social security thing. But he hasn't done much as far as this hospital thing is concerned and for people in my position.

Mr. EDGAR. Well, he has done a lot in nagging me to get things moving.

Mr. GOLDEN. Well, he hasn't done enough, evidently.

Mr. EDGAR. Blame me, don't blame the gentleman.

Mr. GOLDEN. OK. From now on I'll get on you, OK?

Mr. EDGAR. That's very good. I have a card available in case you need to get to my office.

Mr. GOLDEN. I'll take that.

I thank all of you for listening to me and putting up with me. Thank you very much.

Mr. EDGAR. I appreciate that.

I will yield just 30 seconds to Mr. Nicholson. We really are pressed for time. I apologize for having to limit the time.

STATEMENT OF JOHN NICHOLSON

Mr. NICHOLSON. I am John Nicholson, Mr. Edgar, Mr. Mollohan and Mr. Staggers. I have been here at this hospital for 16 years as a volunteer, and all these people know it. I came over here my first time when I had a heart attack. What happened? Another heart attack, another heart attack, then open heart surgery. After open heart surgery I'm still here. I'm a diabetic. I have to take two shots of insulin a day. I have to watch my heart. I have to take my Inderal. Still I keep active. If I wasn't active—they only gave me 6 months to live, and that was 14 years ago.

Mr. EDGAR. You have done very well.

Mr. NICHOLSON. In this hospital here, we take care of the outpatient. Even myself one time, I was down there in the outpatient and I never had my insulin and had to wait until 10 o'clock. But it happens that they get them cards mixed up or something.

Mr. EDGAR. I thank the gentleman for his comments. Thirty seconds is not a lot of time, but we appreciate your testifying.

Mr. NICHOLSON. Another thing——

Mr. EDGAR. If you could be very brief.

Mr. NICHOLSON. Another thing, down there in outpatients, like Tony says, he has to turn down 48 percent of them. If they come in

there and say they're an alcoholic, they admit it. Then he's going to sign them up and get them on up to the sixth and then bring them back down on the wards.

Mr. EDGAR. I thank the gentleman for his comments.

Mr. NICHOLSON. Thank you.

Mr. ZICKEFOOSE. I would like to call your attention to something of which I was just reminded. That was the civilian insurance that we carry. It just seems to me that that clause where they won't pay in a governmental hospital should not be there. We pay for the insurance and I think the VA should be reimbursed.

Mr. EDGAR. Let me just comment on that, because I offered the amendment in our committee to get third party payment and to change the national law. We did change it partially.

If a patient would have an automobile accident out in front of this hospital and be rushed inside, up until recently you couldn't get any third party payment. We did open it up a little bit to receive some third party payment. I happen to agree with the two of you.

I have to say that your national organizations don't agree with us. They have testified from time to time in Washington that the problem is, if you start opening up those insurance plans and the VA starts taking third party reimbursement, that somehow we will mainstream the system and it will get all confused.

I don't agree with that. I think if there is a veteran who wants to come to a VA hospital and they have Blue Cross and Blue Shield, or if they have some private health care, I think that health care insurance should pay part of the tab. I think if we used that third party reimbursement much more aggressively and changed both state and national law to do it, we might find ourselves a pool of funds that we could use to lessen the burden of health care within the system. It is a very controversial issue; I want you to know that. I hope that when you go to your national conventions or send representatives to your national conventions they will raise that issue because I think it is an issue that we ought to look at, ways to get third party reimbursement and use that as a way to help fund part of the VA health care network.

I don't have any additional questions for you. You have all been patient. I will yield to my colleagues in a second.

Let me congratulate you for coming today. I know a number of you volunteer within the veterans health care system. We didn't ask this of the VA staff, but my guess is that this hospital couldn't function without the volunteers provided through the auxiliaries and through the veterans organizations. I know the VA health care system across the country is better for the kinds of volunteers we are able to generate, and the service officers who work very hard to help alleviate many of the problems with the VA staff. I want to congratulate you for that.

I yield now to Mr. Mollohan.

Mr. MOLLOHAN. Thank you, Mr. Chairman.

As we bring this hearing to a close, I would first like to thank you again, most sincerely, not only for your real interest in Congressman Staggers and I both during our first years in the Congress, but also for the commitment of your time and your interest as demonstrated by coming here and spending a whole day in West

Virginia. We sincerely appreciate it. I know the veterans of West Virginia appreciate it. Thank you very much.

I just want to comment that our purpose is to plan, as I said, for the future of veterans in our state and in our area. I have enjoyed the relationship that I have, a very good working relationship, with the members of this hospital and the staff. They are outstanding and dedicated people. This has given us an opportunity to explore in depth a number of concerns so that we will be better prepared in order to develop programs to meet that future.

I want to express my real sincere appreciation for the hard work, not only on a day-to-day basis, which the administration and staff of this hospital provide and make it work, but also for their hard work in preparing for this hearing. I think it has allowed us all to focus in on the problems and make us better capable of addressing them.

I would also like to express my appreciation to the service organizations as they are represented here, and their auxiliaries, without which they wouldn't be able to function. I appreciate their input here today.

Also, I would like to take this opportunity, from the bottom of my heart, to express my appreciation for the working relationship I have with them. I know during this past year I have learned a tremendous amount about veterans that I never even thought of before, and in large part it has been because of my close working relationship with the veterans organizations.

There are two gentlemen in the audience, Virgil Hartzog and Olin Lehman, who I would like to especially acknowledge. They are veterans extraordinaire and I appreciate their being in the audience today. I know of their real interest and concern for veterans. I have been with them recently on a number of occasions and enjoy a good working relationship with them.

Again, thank you, Mr. Chairman, and thank you all for attending the hearing.

Mr. EDGAR. Thank you.

Mr. Staggers.

Mr. STAGGERS. Mr. Chairman, I want to take the opportunity to thank you also for coming in to West Virginia and for the leadership you have given us over the last year-and-a-half. I want to thank the members of the panel who have testified and for their comments, and I particularly would like to thank Mr. Stump for his compliments to both me and Mr. Mollohan and our fathers.

As an outsider looking in to Congress, I always admired Alan's dad, Bob Mollohan, for the good service he gave to his district. As an insider, now looking at the Mollohan family, I even admire Alan more than I did his father. I think, though, when you combine that he is a hard working, intelligent, caring person, that the constituents of his are very fortunate. I hope you are aware of that and would recognize the fact that Alan probably is one of the hardest working Members of Congress. He is very intelligent and he brings that intelligence with caring to his people. He brings that in his commitment to you people. I think you should recognize that.

Mr. MOLLOHAN. Thank you very much, Bucky. I appreciate that. That was unsolicited.

Mr. EDGAR. Thank you. I would just like to close on one comment, Mr. Golden, about the work in terms of the clinical unit. There hasn't been a veterans meeting in Washington where the chief medical director, Dr. Custis, has not been questioned by your Congressman, Mr. Mollohan, about that clinical unit in terms of accelerating the planning phase and the construction phase. We would like to see the discretionary funds used now so that the October 1 funding is advanced and moved ahead so that we can hopefully cut 6 months to 1 year out of the construction of that clinical unit. The pressure has to be kept on.

There are 172 hospitals. There are conflicting demands. We have a Congressman by the name of Dan Mica who reminds us that 5,000 new veterans are moving in every month to the State of Florida and we have all these extraordinary needs for new facilities. I try to convince them that we need also to care about those existing facilities that need clinical units and expansion and rehabilitation of existing services. I will continue to try to sort out the priorities to make sure that budgets are met.

I want to also comment on something else you said. There is a lot of talk in Washington about cutting budgets, and there is a lot of expenditures on MX missiles, B-1 bombers, neutron bombs, nerve gas cannisters. We have committed ourselves to $2 trillion in expenditures over the next 5 years in defense. And while most of you would support higher defense commitments, those dollars are either borrowed or they are taken away from other programs. The veterans community is not sacred. The Reagan administration wanted to take a big chunk, $900 million, out of the hide of the veterans budget. We restored half of that, and in the last couple of years they have not gone as aggressively to the health care budget.

I saw an interesting statistic and chart which Dr. Custis showed me, which has troubled me ever since I saw it. That is, from 1970 to 1984, the actual dollars expended on veterans health care have stayed constant. Services have increased drastically. The number of dollars has increased, but in terms of their spending power, it is back at the 1970 level. We just put that chart into our report to the Budget Committee to point out that many of the expanded services within the veterans health care system have been created by cannibalizing the system, or by squeezing personnel here to service needs there, or by taking this piece of equipment and utilizing it in a different way. I think we really have to be careful not to let that happen in the future. With a $200 billion deficit this year, next year, the following year and the following year, there is going to be enormous pressure to look for additional cuts in the discretionary areas of the budget. So we are going to need all of the service organizations to help us set some priorities nationally, and we're going to need as much help from the Congressmen as we can to make sure this administration, or whatever administration follows it, recognizes that when you increase the veterans health care budget by "x" number of dollars, if that increase is below inflation, you're actually spending less on delivering that service, at the very time you have growing numbers of aging veterans, atomic veterans who are looking for help, Vietnam veterans who have post traumatic stress disorder, agent orange, female veterans who are coming into the

system, an enormous increase in volume and number, and these needs have to be met to provide quality care.

I want to thank everybody for your patience and consideration. The gentleman who has his Cub Scout fingers up will be recognized as the last.

Mr. BANASSO. I would like to make one statement to the committee, if I might. I have scrupulously remained from saying anything today, and for me that's a major accomplishment. But for your colleague from Florida, a little known fact about the veterans of the State of West Virginia. Per capita, more veterans were drafted out of the State of West Virginia in World War II, the Korean war, and the Vietnam war. More veterans were wounded and more veterans were killed. So you might want to remind him of that when he talks about the great State of Florida.

Mr. EDGAR. We will remember to remind him, and then he'll add up how many veterans from West Virginia have just come down to Florida and rub our noses in it. [Laughter.]

No, I appreciate that statement. I think the veterans from West Virginia are to be commended for that kind of service to their country. On that note, we will close the hearing.

Thank you.

[Whereupon, at 5:20 p.m., the subcommittee was adjourned.]

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